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DO CALORIES MEASURE THE VALUE OF FOOD?*

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As the attention of physicians is being called more and more to problems of nutrition and their solution, it may not be out of place to reexamine some of the foundations of our teachings and see if they are altogether sound.

CALORIES AND FOOD VALUES

Much is written and said about calories, as, the food value of a certain substance is so many calories; and there is a suggestion that a calory is a sort of food ingredient, the real value of food depending on the number of calories present.

A calory is a measure of heat, just as grams, ounces or pounds are measures of weight. If a table of food values was prepared which stated that a definite quantity of milk yielded 6 pounds, meat 8 pounds, bread 4 pounds, and soup 1 pound, the natural question would be, "Pounds of what?" Scant attention would be paid to any one dwelling on the value of particular foods, because the pounds were there. Is it any more rational always to dwell on the value of a definite quantity of food simply because it contains so many calories? The most diverse kinds of food may have the same caloric value but a very different nutritive value.

The calory method of feeding is based on the assumption that nutrition processes depend solely on the oxidation of food, and that the heat given off as the result of the oxidation is the sole measure of the value of the food. In practice, the tendency is to keep a table of calory values from which a diet is made out by an arithmetical process, and the physician is likely to feel that if the calory count is correct, the food problem is properly solved.

In experimental nutrition, however, it is soon found that nutrition is not a simple oxidation process. Many feeding experiments have been conducted with animals to see if food materials from different sources, having supposedly the same chemical composition and yielding the same number of calories as the result of oxidation, have the same practical food value. One of the most notable of these experiments was made by Hart, McCollum, Steenbock and Humphrey[1] at the Wisconsin Agricultural Experiment Station with a large number of animals over a period of four years, and some of their remarks and conclusions make interesting reading. They say, in part:

> There is evidence from the data that there is a distinct and important physiologic value to a ration not measurable by present chemical methods or dependent on the mere supply of available energy. While the latter are important and give valuable data for a starting point, they are, nevertheless, inadequate as final criteria of the nutritive value of a feed. . . . Probably none have felt the limitation of mathematically constructed feeding standards more than those who have taken a prominent part in their development, and even the practical and successful feeder uses these standards only as a help, varying the kind, as well as the proportion of total nutrients in the ration to meet the requirements of the individual. The kind of nutrients, however, receives his attention only when their effects are extremely pronounced and immediately apparent. . . . But in addition to the limitation of mathematical standards, which consider only digestible nutrients, or the total net available energy of a ration, there are still other important factors that must be considered. We refer to what may be called the *physiologic value* of the ration. . . . There are many different proteins, in addition to nitrogen-bearing bodies of nonprotein character; fats of different compositions and degree of saturation; carbohydrates of many types; and almost a host of undetermined and undefined bodies in the daily ration of a domestic animal. . . . Unquestionably the *physiologic* value of a ration is largely dependent on its chemical constituents, but the usual determinations made on feeding materials do not reveal the character or manner of combination of many of the constituents. Consequently, the physiologic value can be determined in the present state of our knowledge only by long continued observations of the reaction of the feed on the animal.

Since the foregoing experiments were conducted, animal feeding experiments have been widely carried on, and it seems to be the universal finding that the number of calories a food yields on oxidation is not at all an indication of its feeding value. Bayliss[2] says:

> Heats of combustion do not necessarily give the actual energy value of foodstuffs as available in the organism. . . . In the animal body, energy is derived from chemical combination. This form of energy is readily converted into various other forms without the necessity of passing through the form of heat.

ANAEROBIC AND AEROBIC REACTIONS

At this point it may be well to call attention to a fact not generally known, namely, that large quantities of the common foods are used by animals by anaerobic metabolism, since air is not essential to animal life in all cases. Mammals and birds quickly die from lack of oxygen. Frogs may remain alive for days in an atmosphere containing no oxygen. Fish and reptiles

* Read before the American Pediatric Society, Atlantic City, N. J., June, 1919.

1. Research Bull. 17, University of Wisconsin Agricultural Experiment Station.

2. Bayliss, W. M.: Principles of General Physiology, New York, Longmans, Green & Co., 1915.

may live without air for some time, while insects will live and be active in a vacuum for several days. Leeches can live ten days without oxygen. Bunge[3] says:

> I have made many experiments with the roundworm of the cat, and have satisfied myself that these animals can live in media entirely free from oxygen for from four to five days and be extremely active during the whole time. Whoever has seen these movements must be convinced that oxidation is not the source of muscular energy in these animals.

It is evident that animals which eat the common foodstuffs and obtain energy from them for days at a time in the absence of oxygen do not carry on their vital processes and obtain energy as the result of oxidation, and that for them the amount of heat that can be produced by oxidation of the food they utilize is of no interest.

In the bodies of higher animals it appears that the processes of nutrition are a combination of anaerobic and aerobic reactions. From reading Bayliss it would seem to be fairly well settled that the primary processes in the bodies of higher animals are anaerobic, and that the aerobic processes are secondary. The contraction of the muscles is an anaerobic process:

> There is neither consumption of oxygen nor evolution of carbon dioxid. It is not an oxidation process. . . . To restore the potential energy which the system has lost in contracting, energy is supplied by another reaction of a chemical nature, which succeeds the contractile stage. . . . The energy required for the second process is afforded by a reaction in which some substance, carbohydrate or fat, is oxidized. Much oxygen is used and carbon dioxid given off. . . . Consideration of life without oxygen leads to the view that the actual source of the free energy required by a living organism is a secondary matter. If it cannot be obtained by oxidation, other chemical reactions, although of a less efficient kind, are made use of.

If this is the case, it is easy to understand how the large number of animals that can live without oxygen obtain their energy—they simply use more food and discard it at the point at which oxidation begins in the aerobic animals.

VALUE OF THESE FACTS TO THE PHYSICIAN

These facts are of much importance to the practicing physician. He is required to solve numerous problems which call for the selection of food of the right *physiologic value* for a given individual. What may be the right physiologic value for one may not be suitable for another. It is possible that the difficulty lies in a perversion of anaerobic metabolism in one case and aerobic metabolism in another. It has been conclusively shown that in practice the caloric value of a food is no strict indication of its nutritive value, but it has not been shown why this is so. With the recognition of the fact that an animal body is not merely a furnace in which food is burned, but that a long series of chemical changes in the food takes place, it is not difficult to see why practical results often cannot be obtained with foods valued only by their oxidation properties. To quote Bayliss again:

> The general conclusion seems to be justified that the cell mechanisms are such as to be able to use chemical energy whether it comes from oxidation or otherwise, and that they are independent of the particular chemical reaction which affords it.

The animal body is highly complex, with a metabolism that is in part anaerobic and in part aerobic, as some tissues live by the former process and others by the latter.

SUMMARY

Heat or energy may be produced by chemical cleavage as well as by oxidation. Heat may be a degradation of energy, and in the human organism it is an excretion. Heat measurement alone is not a safe guide for the calculation of food values. This is especially true at the beginning of life when growth is the all-important factor. The foods that *build* rather than those that readily undergo oxidation must be properly gaged if we are to have healthy development.

A false theory does harm in that it points in the wrong direction, and it is a question whether it is not time to weigh carefully the calory theory of feeding and restrict or partially abandon its use. To take its place, a system of teaching must be constructed based on a knowledge of the physiologic properties of the various food elements and the fact that there are mixed types of metabolism. Some form of biologic testing of foods must be elaborated if an always reliable gage of nutrition is to be established.

51 West Fifty-First Street.

3. Von Bunge, Gustave: Text-Book of Physiological and Pathological Chemistry, Philadelphia, P. Blakiston's Son & Co., 1902.

ANAPHYLACTIC DEATH IN ASTHMATICS *

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The increasing frequency with which antitoxic serums are being administered, both for curative and for prophylactic purposes, and the increasing number of diseases for which antitoxins can be prepared, make the subject of anaphylactic death of particular interest to the clinician. That many cases of bronchial asthma are the result of sensitization to the emanations from horses presents an added complication, for the existence of this sensitization makes these persons unusually susceptible to horse serum, and thus it is occasionally dangerous to administer prophylactic or curative serum in amounts sufficient to be effective. There are many cases recorded in the literature in which serious collapse has followed the administration of antitoxic serum, and a few instances in which death has occurred.

It is, of course, needless to remark that the total number of such cases is an almost negligible percentage of the total number of cases in which injection was made. At first, these cases were frankly not understood, or they were ascribed by some to status lymphaticus.[1] Now, however, we recognize that most of these cases of sudden death are due to anaphylaxis —a condition brought on by the sensitization of the patient to horse serum. This sensitization may have been induced during the treatment by the necessity of giving two or more doses of antitoxin over a period of six or more days; or it may have been caused by an injection of antitoxin given for some previous illness (this factor seems to have caused few, if any, deaths); or it may have been due to some unknown cause, and have existed for a long time. A large pro-

* From the Department of Pathology of the University of Illinois College of Medicine.

1. Park: Harvey Lecture, Jan. 20, 1906.

portion of these sudden deaths are found to occur in asthmatics. Thus Gillette[2] reports a case of his own, and has collected from the literature and by personal correspondence twenty-nine more instances in which collapse or death followed soon after the administration of antitoxic serum. Of these thirty patients, sixteen died and fourteen recovered. Of the sixteen patients that died, ten were in good health at the time of the injection, three were suffering from mild attacks of diphtheria, and in two the degree of illness is not stated. In all the onset and course of the attack were so typical that there can be no doubt that these were genuine anaphylactic deaths. In one (Case 8) there is room for some doubt, as the child was quite sick and lived for ten hours after the injection. In nine of the sixteen fatal cases there was a definite history of asthma. In two of the nine instances, it is stated that proximity to horses brought on the attacks; in the other seven, the exciting cause is not stated. Of the fourteen patients that lived, nine were asthmatic; in two cases, the attacks were brought on by proximity to horses; in the other seven, the exciting factor is not mentioned. In two of the nine instances, the asthma is reported to have been cured (one was a typical horse asthma; in the other the excitant is not stated); in one case, the asthma was definitely not cured; and in the rest, the later course of the asthma is not recorded. Walker[3] has recorded a case of asthma in which the disease was brought on by an injection of horse serum (antitoxin), though it had never been present before the injection. There is at least one other such case in the literature. Sewall[4] records the case of a man who developed rabbit asthma after an injection of rabbit serum.

In all the recorded cases of serum anaphylaxis, the history of the attack is strikingly constant. Almost invariably it begins within two or three minutes after the injection, but in one recorded nonfatal case (Gillette's Case 6) the attack did not begin for twenty-four hours, but then it was perfectly typical. In fatal cases, death usually occurs within five minutes after the injection, though occasionally it is postponed for from thirty to forty-five minutes. The most prominent symptom is dyspnea. This may be accompanied by pain, either at the site of injection, or in the chest or head. Headache is very common. A marked cyanosis usually comes on at once, and frequently urticaria or edema is present. A sense of impending death occasionally occurs. The heart usually remains strong, and continues beating long after respiration has ceased.

In three of the cases reported by Gillette, postmortems are recorded. In the Langerhans case no anatomic lesions were found beyond an enlarged thymus. In Gillette's own case the postmortem report states that the lungs were larger than normal and passively congested. There was an adhesion of the pericardium to the heart (there was a history of rheumatism for several years). The kidneys were softer than normal, and more moist. The spleen was engorged with venous blood, dark and granular. Otherwise all organs were negative. In one other case, the postmortem report states that "the lungs and cavities of the heart were in such condition as could only be brought about by sudden and extreme spasm, such as might be accounted for by an acute attack of asthma." I have collected records of several other cases of anaphylactic death which will be reported elsewhere in detail, but in none of these cases is a history of asthma recorded.

There are in the literature the reports of nine cases of bronchial asthma with postmortem records. Ellis[5] has collected records of seven and has reported one, and Brown[6] has added another. In Brown's case, the patient died from pneumonia. He had been suffering from myocardial insufficiency and cirrhosis of the liver; he had had no asthma for the last two or three months of his life. In the other cases, death occurred during an asthmatic attack, but the postmortem report covers only the condition of the lungs. In none of these cases is the exciting cause of the asthmatic attacks mentioned. It is impossible to show any direct relationship between these cases and anaphylaxis.

REPORT OF CASE

History.—A man, aged 29, who, for the last ten or twelve years, had been subject to attacks of bronchial asthma when in proximity to horses, and who had read a good deal, and was informed on the relationship of anaphylaxis to asthma, was anxious to have a desensitizing dose of horse serum, although he was familiar with the danger. He was taken to a hospital, and 1 minim of normal horse serum was administered intravenously.

Within two minutes a typical attack of asthma supervened. He was given 10 minims of epinephrin (adrenalin) intravenously, with definite relief for about ten minutes. In all, 50 minims of epinephrin were given in five doses, intravenously. Each gave relief for several minutes; but eventually the patient died, forty-five minutes after the injection of serum. The postmortem was performed within an hour and a half after death.

Postmortem Findings.—The body was very slender; the waist was narrow; the ribs were "dished in" at the level of the lower end of the sternum. The face was cyanotic; the lips were swollen, but herpes was not present. The body was still warm; postmortem rigidity was not present. There was very little subcutaneous fat.

The abdominal cavity showed intense injection of the vessels everywhere, being especially marked in the veins of the stomach, mesentery, gallbladder and appendix. The entire small intestine was bright red, and the dilated submucous vessels showed distinctly through the intestinal wall. The parietal peritoneum was markedly injected. No exudate was visible in the peritoneal cavity.

Both lungs were enormously distended and emphysematous. The left lung showed a small area of hemorrhage on the lateral portion of the lower lobe, about 4 cm. in diameter, with a gelatinous organizing exudate at this point. On section, the lungs were found to be dry. The right pleural cavity was largely obliterated by firm, fibrous adhesions. No fluid was present in either cavity. The thymus was not enlarged.

The pericardial cavity was negative. The heart was firm and of normal size and appearance, except for a few minute subpericardial petechial hemorrhages on the posterior surface.

The liver, which was paler than normal, extended to a point one inch below the umbilicus. No gross structural change was noted. The gallbladder was markedly injected.

The stomach showed the "hour-glass" configuration (postmortem?). The veins on the greater curvature were enormously distended. There were no subserous hemorrhages. The mucosa was negative.

The spleen was negative except for the presence of a number of small, reddish brown bullae, about 1 mm. or less in diameter, located in a group of from twenty to thirty along the anterior border.

2. Gillette, H. F.: Untoward Results from Diphtheria Antitoxin with Special Reference to its Relation to Asthma, New York State J. M. **9**: 373, 1909; Therap. Gaz. **33**: 159, 1909.

3. Walker, I. C.: The Treatment of Patients with Bronchial Asthma by Subcutaneous Injections of the Proteins to Which They are Sensitive, J. M. Research **36**: 423 (July) 1917.

4. Sewall, Henry: Some Relations of the Brain and of the Olfactory Apparatus to the Processes of Immunity, Arch. Int. Med. **13**: 856 (June) 1914.

5. Ellis, A. G.: The Pathological Anatomy of Bronchial Asthma, Am. J. M. Sc. **136**: 407, 1914.

6. Brown, O. H.: Asthma, St. Louis, C. V. Mosby Company, 1917.

The kidneys were about normal in size; the capsule was smooth; there were no dilated veins on the surface. On sectioning, there was a marked hyperemia, but no other change. The suprarenal was negative.

There was a Meckel diverticulum about 12 cm. long with a slight constriction at the tip.

Microscopic Examination.—Lungs: There was moderate passive hyperemia, but no edema. There were a few small interstitial hemorrhages. A little mucus, and a few desquamated epithelial cells were seen in some of the bronchioles. The peribronchiolar muscle was well developed. A few arteries showed greatly thickened walls, and many showed moderate thickening of the walls.

Heart: There were several small hemorrhages in the myocardium. There was one small area of old scar tissue. A few small vessels showed thickened walls, and a few showed proliferation of vascular endothelium.

Kidney: Here the most marked changes were seen. The epithelium of the convoluted tubules was distinctly edematous, and there was considerable degeneration and some necrosis. There was intense passive hyperemia. Interstitial hemorrhages were numerous, but not extensive. There were no chronic changes.

Suprarenal: There was marked passive hyperemia, and there were a few minute hemorrhages.

Spleen: There was moderate passive hyperemia, and there were a few small hemorrhages. Most of the smallest arteries and many of the larger arteries showed a marked edema of the wall. Eosinophils were very numerous. In one large vessel, 500 leukocytes were counted with 6 per cent. of eosinophils. In one high-power field, sixty-five eosinophils were counted, which were estimated to be 5 per cent. of the total number of cells present.

Liver: There was very marked edema involving practically all of the parenchymatous cells. There was no passive hyperemia, and there were no hemorrhages. Very few small areas of round cell infiltration were present. Many small arteries showed marked thickening of the walls. No areas of necrosis or scar tissue were seen.

COMMENT

This case is of special interest for several reasons:

First, because of its relation to the recently popularized desensitization method of treating those cases of asthma (and of certain other clinical conditions) which show sensitization to specific proteins. Undoubtedly, this patient should have been treated with high dilutions of serum as advocated by I. Chandler Walker[8] instead of the undiluted serum.

Second, because of the very small amount of serum which produced death. Of the other recorded cases, probably the Langerhans case (in which 1.2 c.c. of serum were used) involved the smallest amount of serum. In one recorded instance, an infant received 600 units of diphtheria antitoxin; one adult received 800 units, and one 1,000 units: in three instances, one adult and two children, "an immunizing dose" was given. In the nonasthmatic cases that I have collected, the fatal dose has usually been larger than in this series.

Third, because of the striking similarity in appearance of the organs in this case to those in experimental anaphylaxis in animals. The enormous distention of the lungs, the intense passive hyperemia of the abdominal organs, and the occasional subserous hemorrhages are highly characteristic of experimental anaphylaxis.

Furthermore, this is the only case of death from acute anaphylaxis, uncomplicated by other morbid conditions, that I have been able to find in which microscopic studies have been made. Koch[7] has reported necropsy findings in a case of anaphylactic death in a child with scarlet fever and suppurative tonsillitis; but the microscopic findings are all referable to the infection present.

Further, we are able to observe here a case in which repeated anaphylactic shocks have been experienced, and thus to study the cumulative effect of this intoxication. Undoubtedly, the repeated asthmatic attacks to which this patient was subject have not meant as severe intoxication as is usually experienced by laboratory animals in experimental work, yet it is interesting to note that the edema, degeneration and necrosis of the epithelial cells of the liver and kidneys and the thickening of the arterial walls in spleen, liver, lung and heart correspond closely to the changes that I have previously described[8] in experimental chronic anaphylaxis.

It has been well known for a number of years that one must exercise extreme care in giving curative serums to asthmatics. No satisfactory method of desensitization has yet been discovered to make safe the administration of serum to asthmatics with acute infections, such as diphtheria, in which time is such an essential factor in treatment. Besredka's method of "doses subintrantes"[9] has not justified the claims originally advanced for it; and Weil[10] has pointed out grave objections to its use as a routine. At best, the methods of desensitization are uncertain. In experimental work, animals sensitized with a small dose of serum can be desensitized with a small dose. Animals sensitized with a large amount of serum require a relatively large amount to effect desensitization—an amount, indeed, that would be fatal to an animal sensitized by a small dose.[10] Since we cannot know whether man should be desensitized by a large or a small dose, this method is unsatisfactory for practical use. The giving of a series of doses of gradually increasing size may, in some cases, produce desensitization, but in others it will bring on a fatal attack of anaphylaxis instead.[11] Of course, the intravenous method of administration in these cases is more dangerous than the subcutaneous. And yet in only a small number of cases is the danger great. Walker,[12] in an analysis of 150 cases of asthma, found that only 20 per cent. were due to horse proteins, and of these but 20 per cent. (or only 4 per cent. of the entire series) were sensitive to horse serum: the rest were sensitive only to horsehair protein. When it is desired to give a curative serum to an asthmatic, it would be well to make first the cutaneous test with diluted serum to see if he is sensitive to horse serum. If not, the therapeutic dose would probably not produce serious symptoms. For the benefit of those asthmatics who are sensitive to horse serum, it might be worth while to prepare curative serums from other animals than the horse.

SUMMARY

A certain proportion of asthmatics (4 per cent. in Walker's series) are sensitive to horse serum. In

7. Koch, W.: Beitrag zur Kenntnis der Serumanaphylaxie beim Menschen und deren Verhütung, Berl. klin. Wchnschr. **52**: 685, 1915.

8. Boughton, T. H.: Studies in Protein Intoxication, I, II, III, J. Immunol. **1**: 105 (Feb.) 1916; **2**: 501 (Aug.) 1917; **4**: 213 (July) 1919.

9. Besredka: Le procédé des petites doses et les injections subintrantes, Ann. de l'Inst. Pasteur **24**: 879, 1910.

10. Weil, R. W.: Desensitization: Its Theoretical and Practical Significance, J. M. Res. **39**: 233, 1913.

11. Netter: Bull. de la Soc. d. Hôp. de Paris **33**: 401, 1912. Gryzez and Dupuich: Ibid. **33**: 374, 1912. Doerr, in Kolle and Wassermann: Handbuch der pathologischen Microorganismen, 1913, p. 1082.

12. Walker, I. C.: Studies on the Causes and Treatment of Bronchial Asthma, J. A. M. A. **69**: 363 (Aug. 4) 1917.

these the injection of horse serum (antitoxin) may produce serious symptoms or death. As compared to nine previously recorded cases of anaphylactic death in asthmatics, an added case, in which death resulted from the intravenous injection of 1 minim of horse serum, presents an instance of the smallest amount of serum that has produced death in any recorded case. Both the gross and microscopic appearance of the organs at necropsy show a striking similarity to lesions previously described in experimental anaphylaxis. There is uncertainty in existing methods of desensitization. Asthmatics who require curative or prophylactic serums should be tested by the cutaneous method to determine their sensitiveness to horse serum. If they are not sensitive to horse serum, therapeutic doses of antitoxin are probably safe. It might be well to prepare antitoxins from other animals than the horse for use in patients sensitive to horse serum.

ACUTE DILATATION OF POST PARTUM UTERUS AS A CAUSE OF POST PARTUM HEMORRHAGE

ITS ANALOGY TO ACUTE DILATATION OF THE STOMACH, WITH A SUGGESTION ON THE ACTION OF INVOLUNTARY MUSCLES: PRELIMINARY REPORT

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Acute dilatation of the post partum uterus may occur: (1) during the third stage of labor in which the placenta and membranes are still in utero, and (2) in the early puerperium, uncomplicated by the placenta and membranes which have been discharged.

1. In the third stage of labor, the uterus has a function to perform: the separation and discharge of the placenta and membranes. As the child is being born the fundus follows the child until it is stopped by the bulk of the placenta which it snugly surrounds. The liquor amnii, usually clear, though it may be highly tinged with blood, is discharged, with some bright blood following. The uterus slightly relaxed, globular in shape, and situated below the umbilicus, gives good evidence of muscular tone. After a half dozen pains the placenta and membranes have become separated and are pushed down into the lower uterine segment and vagina. The fundus rises, having become pear-shaped, and is found in the median line below the umbilicus; being well contracted, its outline is well marked. The flow of blood is not great, and normally no clots are present. The average loss of blood during a normal labor is less than 500 c.c.[1] In contrast to this picture, acute dilatation in the third stage of labor presents a uterus which has increased in size until it may fill the abdomen. Its limits are ill defined; its walls, instead of being resilient, are soft and doughy. The placenta and membranes are still retained in the uterus, and the uterine cavity fills with blood. By vis a tergo the hemorrhage, unless blocked by the membranes in the lower uterine segment, appears at the vulva, where it is recognized as a post partum hemorrhage. The time of onset of the acute dilatation is not fixed, but it comes on while the uterus is apparently functionating normally.

2. Acute dilatation in the early puerperium occurs usually within half an hour, though it may happen within the hour, rarely later. The normal puerperal uterus at this time is in the median line; its fundus is felt midway between the umbilicus and the pubis. The size of the individual uterus varies. Its outline is well marked, it is well contracted, and the membranes and placenta are entirely discharged. There is present only a slight lochial hemorrhage. By the end of an hour the uterus, being larger but not losing its muscular tone, has risen to or near the umbilicus. In acute dilatation, however, the uterus may extend above the umbilicus, or it may be but little larger than many post partum uteri functionating normally. Its walls are softer and they have lost their muscular tone, allowing the blood to escape from the open sinuses of the placental site. It is obvious that the bleeding is not so rapid as in the third stage, yet this post partum hemorrhage is free enough to cause death within an hour or two. Cragin,[2] in speaking of this condition, calls it "ballooning of the uterus with its accompanying hemorrhage." Hemorrhage from other portions of the post partum uterine endometrium must of necessity be slight in comparison to that from the placental site.

Under normal conditions after the birth of the child, the uterus contracts and retracts closing the sinuses and, following a few pains, the placenta and membranes are discharged. No unusual hemorrhage occurs. The placenta, however, in some cases is retained, and yet there is no hemorrhage. That retention of the placenta in itself is not deleterious is shown by the fact that articles[3] appear from time to time issuing a word of warning against any mechanical interference with the uterus, as with the Credé method, before the placenta has had time to separate. The most common danger of retained placenta and membranes or portions of them is that they may become splendid culture mediums, causing puerperal infection.[4]

When an excessive quantity of blood appears at the vulva after childbirth, the place from which the hemorrhage is coming must be determined. If hemorrhage from the cervix, circular sinus,[5] or lower birth canal can be excluded, it is a post partum hemorrhage from the placental site. Hemorrhage from the placental site is due to the lack of pressure which should control the flow of blood from the uterine sinuses. Serious bleeding may occur even after the expulsion of the placenta. Williams[6] and other writers state that "the danger of hemorrhage does not end with the expulsion of the placenta, as the uterus sometimes relaxes during the hour immediately following" labor.

Acute uterine dilatation must not be confused with uterine inertia.[7] If there is retention or delayed sep-

1. Ahlfeld: Ztschr. f. Geburtsh. u. Gynäk. 51: 341, 1904.

2. Cragin: Obstetrics, Philadelphia, Lea and Febiger, 1916.
3. Gibson, H. K.: Surg., Gynec. & Obst. 24: 625 (May) 1917. Polak: Am. J. Obst. 72: 150, 1915.
4. Lea, A. W. W.: Puerperal Infection, London, Oxford University Press, 1910.
5. Budin, P.: Femmes en couches et nouveau-nés, Paris, O. Dorn, 1897, p. 143.
6. Williams: Obstetrics, Ed. 4, New York, D. Appleton & Co., 1917.
7. For a consideration of uterine inertia, the following authors may be consulted:
Edgar: Tr. Am. Gynec. Soc. 38: 28, 1913.
Cragin: Tr. Am. Gynec. Soc. 38: 39, 1913.
Freeland: Am. J. Obst. 69: 302, 1914.
Rice, F. W.: Am. J. Obst. 74: 215 (Aug.) 1916.
Gardiner: New York M. J. 100: 1067, 1914.
Tweedy, E. H., and Wrench, G. T.: Practical Obstetrics, Ed. 3, London, Oxford University Press, 1912.
Titus, Paul: Uterine Inertia, J. A. M. A. 71: 890 (Sept. 14) 1918.
Wagner: Wien. klin. Wchnschr. 28: 774, 1915.
Bischoll: Zentralbl. f. Gynäk. 38: 549, 1914.

aration of the placenta without hemorrhage, uterine inertia is present. If there is retention of the placenta with hemorrhage, exclusive of birth injuries and other pathologic uterine conditions, acute uterine dilatation is present.

The three cases outlined herewith illustrate the different types of acute post partum uterine dilatation:

REPORT OF CASES

CASE 1.—Mrs. B., sextipara, had spontaneous labor, the second stage of which was short. The child weighed 10½ pounds. The placenta and membranes were discharged intact fifteen minutes after the birth. The uterus was well contracted, and there were no injuries to the birth canal. The lochial hemorrhage was normal. Fifty minutes after the birth, the uterus extended above the umbilicus; its walls were soft and doughy. There was a profuse hemorrhage, and the patient was nearly exsanguinated. Under active bimanual stimulation the uterus contracted to midway between the umbilicus and pubes. Recovery was uneventful.

CASE 2.—Mrs. McN., secundipara, after normal labor gave birth to a child weighing 10 pounds. The uterus contracted down on the placenta after the birth. Within ten minutes the uterus had increased in size until the fundus was midway between the ensiform cartilage and the umbilicus, filling the abdomen. The uterine wall had lost its muscular tone. The woman showed signs of hemorrhage, though none appeared at the vulva. By bimanual compression and the Credé method the uterus contracted, expelling intact the placenta and membranes and many clots, until the fundus was 10 c.c. above the pubes. The cervix and lower birth canal were not the seats of any hemorrhage, only a small perineal laceration being present. The patient made a good recovery.

CASE 3.—Mrs. S., secundipara, after labor, the first stage of which was prolonged, owing to an unyielding cervix and the second stage was very short, owing to a relaxed perineum, was in apparently good condition thirty minutes after the birth, when I saw her: the skin was of good color, the pulse was 100, and the fundus was midway between the pubes and the umbilicus. The membranes and placenta were discharged entire about ten minutes after the birth. Forty-five minutes after the birth the patient showed signs of hemorrhage, the skin was pale, the lips were blanched, and air hunger was present. There was some vulvar hemorrhage present, but it hardly seemed enough to account for the severe symptoms, and as there were no injuries to the birth canal, and as the uterus appeared contracted, other sources of the hemorrhage were quickly looked for with no result. Further examination revealed that there had been considerable oozing of blood through the vulva. Then the uterus was grasped and under the Credé method it contracted down behind the pubes to the size of a two months pregnant uterus. Further recovery was not interfered with.

COMMENT

The uterine muscle is an involuntary muscle and possesses the characteristic of involuntary muscles—rhythmic contraction. Of the physiologic action of involuntary muscles little is known.[8] What is known has been gained chiefly from the experiments on the intestine, ureter, bladder and retractor penis. It is recalled that stimulation of a voluntary muscle causes a wave of contraction to travel to each end of the fiber, but no farther. As a rule, a stimulus applied to any part of a sheet of involuntary fibers may travel all over the sheet, just as if it were a simple fiber, as in the heart, stomach, and in the contractions of the uterine muscle. The most important form of mechanical stimulation is that produced by tension. The effect of increasing tension on involuntary muscle may be twofold: First, if produced slowly, as in the gradual filling of the urinary bladder, relaxation is the result; second, sudden excitation produces increased contractions. The Lewises[9] reported that the power of rhythmic contraction exists in involuntary muscles in the culture growths of the chick amnion, as an inherent property of the protoplasm of the involuntary muscle, and may be exhibited either by a bundle of cells, by an individual cell, or by a part of a single cell. This is a great advance in pointing out that the movements of involuntary muscles are not dependent entirely on their closely associated network of nerve fibers. Furthermore, they found that when this phenomenon, rhythmic contraction, ceased, it could again be instituted either by touching the cell or by the addition of calcium to the culture medium. The point which the Lewises bring forward is very timely, as many authors speak of a paralysis of the placental site as a cause of post partum hemorrhage. By their experiment, it is seen that the movements of involuntary muscles are not dependent entirely on their closely associated network of nerve fibers. In view of this fact, it appears that involuntary muscle fiber cells and even parts of cells possess the inherent property of rhythmic contraction without any demonstrable nerve control, just as in the ameba. Here, then, one may question the assumption that a true paralysis of the placental site occurs, and affirm rather that it is an acute dilatation or, more properly, a relaxation of the uterine muscle which allows the hemorrhage from the placental site.

All hollow viscera have involuntary muscle walls and seem to possess a property which may cause them to go into acute dilatation after a period of undue stress. It is frequently noticed that an old person in his usual health, after a more than ordinary exertion during the day, may die during the following night. Here, the heart muscle has continued apparently as normal after the period of stress; then later it enters into permanent diastole. The same thing occurs in younger people, after a period of extraordinary strain, such as a sharp run or severe physical exercise, when not in training for it. The heart continues apparently normal for a time, and then goes into permanent diastole. It again occurs as a complication in operations. The stress on the heart muscle may be great enough, even before anesthesia is complete, to cause the heart to enter into permanent diastole. Diastolic rest may also occur in postoperative cases. In severe infections, such as diphtheria, it is sometimes seen.

The involuntary muscular coats of the blood vessels also possess this common action of dilatation, as the dilatation of the abdominal vessels in fainting. This acute dilatation is seen in the vessels about local injuries and infections irrespective of their location in the body. It is possible that this acute dilatation of the blood vessels is one of the chief features in the production of that condition which is generally known as shock.

As there is an acute dilatation of the heart and blood vessels, so there is an acute dilatation of the stomach.[10] Two theories have been brought forward to explain

8. Howell, W. H.: Textbook of Physiology, Philadelphia, W. B. Saunders Company. Stewart: Manual of Physiology, Ed. 4, Philadelphia, W. B. Saunders Company, 1900. Starling: Human Physiology, Philadelphia, Lea and Febiger, 1915.

9. Lewis, M. R., and Lewis, W. H.: Am. J. Physiol. 44: 67 (Aug.) 1917.

10. For a consideration of stomach acute dilatation the following authors may be consulted:
Fagge: Guy's Hospital Reports, 1872, p. 73.
Neck: Centralbl. f. d. Grenzgeb. d. Med. u. Chir. 8: (Aug.) 1905.
Laffer: Ann. Surg. 47: 390 (March) 1908.
Lee, B. J.: Ann. Surg. 63: 418 (April) 1916.

the cause of acute dilatation of the stomach: first, that there is a primary paralysis of the stomach; second, that there is a mechanical obstruction by the mesentery and mesenteric vessels. All cases of acute gastric dilatation give a history of preceding stress, as is shown in postoperative dilatation of the stomach. No matter what part of the body is operated on, dilatation may follow.[11] Gastric dilatation follows delivery—post partum dilatation of the stomach.[12] It is often a complication of acute infections, as in pneumonia. Thompson, who has studied the subject extensively, states that while in no way denying that some cases may be obstructive in origin, he is inclined to believe that a primary paralysis of the organ must be regarded as the underlying cause in the majority of cases. It is suggested that instead of a primary paralysis it is an acute relaxation of the involuntary muscles of the stomach walls which occurs.

The intestine is likewise affected: the condition is known as ileus.[13]

The urinary bladder is another organ which is frequently affected by acute or fatal dilatation, when the body has undergone a period of stress, as is frequently seen following operations, labor, and as a complication in infectious diseases.

From physiologic experiments we learn that involuntary muscles possess the power of rhythmic contraction, and that the walls of the heart, stomach, bladder, uterus and other hollow organs are made up of involuntary muscles and possess the function of rhythmic contraction. The involuntary muscle walls of the uterus reveal an added function during and after labor, that of retraction. Therefore, involuntary muscles under some circumstances have two functions, rhythmic contraction and retraction. Furthermore, the heart, stomach and bladder, after a period of stress, may assume a state of acute dilatation due to the acute relaxation of the involuntary muscle. This same condition I have found in the uterus, and it appears with such dignity and purpose that I have been impressed with the possibility that it may be due to an inherent quality in involuntary muscles. One may object to the dilatation of the uterus theory on the basis of a simple distention caused by the blood, coming from the placental site, accumulating in the uterine cavity and producing distention. The point in the differential diagnosis is that in a distended organ the walls possess a characteristic resiliency or muscular tone, while in acute post partum dilatation the walls of the uterus are soft and flabby, having lost their muscular tone. Williams[6] speaks of a relaxation of the uterine walls post partum; Cragin[2] of a ballooning of the uterus post partum; DeLee[14] mentions that dilatation of the uterus may occur during a curettage. There is, then, an acute dilatation of the uterus, and it is a function inherent in the uterine musculature which may prove rapidly fatal.

Acute dilatation may prove rapidly fatal not only in the post partum uterus but also in acute dilatation of the heart, stomach and bladder. These organs when in a state of acute or fatal dilatation show within a limited time a uniform tendency to respond to stimuli, and may recover to perform their normal function. Several patients with acute dilatation or diastolic rest of the heart are reported as recovering by the employment of cardiac massage. Cardiac massage[15] is employed subdiaphragmatically, through the abdominal wound: the hand grasps the heart and compresses it a few times a minute, and indirectly massage is applied by tapping with the fingers over the right auricle. A unique report is that of Argaud.[16] In a decapitated man, aged 20, Argaud saw spontaneous contractions forty-five minutes after decapitation; from this time to sixty-two minutes, mechanical stimulations, particularly of the right auricle, evoked cardiac contractions. Then he opened the heart, and by electrical stimulation produced a response to the eighty-third minute. He found the most excitable region of all corresponded to the tenia of His, the Keith-Flack node, and the valve of Thebesius, the regions richest in nerve ganglions. He recommended in diastolic rest light taps by the finger tips over the right auricle at intervals of from ten to thirty seconds, watching for myocardial response. Two patients with asphyxia neonatorum[17] recovered by cardiac massage, artificial respiration being simultaneously practiced: one child, after an hour, the other, after three hours.

In acute dilatation of the blood vessels, there is response to stimulation. In fainting, stimulation is produced on the acutely dilated blood vessels by assuming the horizontal position; or, if the cerebral anemia is great, it is produced by the convulsion following. That pressure applied in local infections has a good effect, because of its support of the acutely dilated vessels, is well known. This is exemplified by the fact that many a one advocates the continuous administration of ergot to keep the post partum uterus (its sinuses) well contracted (regarded also as a preventive of puerperal infection). In shock, the blood vessels are acutely dilated; and the advantage of the stimulation produced by massage, bandaging the extremities and abdomen, the Trendelenburg position, and drugs (such as suprarenal extract) is also well known.

It is known that the stomach, when directly irritated, contracts; but in acute dilatation it is impossible for the stomach to relieve itself because of the two sphincters which control the outlets and probably respond to the same stimuli as the muscular walls of the stomach. In this case the only relief is the introduction of the stomach tube.

The bladder responds likewise to stimuli, but here a sphincter also prevents relief, which is obtained only by the use of the catheter.

The acutely dilated post partum uteri in the cases reported responded to stimulation and functionated normally.

This reaction from acute dilatation predicates an inherent property in the involuntary muscle walls.

CONCLUSION

This preliminary report points to the fact that all involuntary muscles possess, besides rhythmic contraction and retraction, the property to functionate normally for a time, after a period of stress, then to assume a state of acute relaxation, and further, within

11. Cohn, T.: Ann. Surg. 63: 263 (March) 1916.
12. Thompson: Lancet 2: 287, 1902.
13. Cannon, W. B., and Murphy, F. T.: Physiologic Observation on Experimentally Produced Ileus, J. A. M. A. 49: 840 (Sept. 7) 1907.
14. DeLee: Principles and Practice of Obstetrics, Philadelphia, W. B. Saunders Company, 1913.
15. For a consideration of cardiac massage, the following authors may be consulted:
Matas: Keen's Surgery, Philadelphia, W. B. Saunders Company, 1909.
Kidd, W. A.: Brit. M. J. 1: 316, 1917.
Weiss: Deutsch. med. Wchnschr. 41: 338, 1915.
Molyneux, E. S.: Brit. M. J. 1: 420 (March 31) 1917.
16. Argaud, quoted by Kidd: Brit. M. J. 1: 497, 1917.
17. Breitmann: Tr. Internat. Cong. Med., London, 1914, V, Therap., Pt. 2, p. 264.

a limited time, to react on stimulation and return to their normal functioning.

The uterus, being made up of involuntary muscle fibers, is subject to the laws governing involuntary muscles.

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SUPPURATION AND GANGRENE OF THE LUNG

A STUDY OF ONE HUNDRED CASES

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Although abscess, gangrene and bronchiectasis belong to the rarer lung diseases, their study is acquiring a greater interest and importance, because we are becoming more familiar with their causation and also because of the increasing possibility of curing them by operative procedures.

In the textbook description of these diseases, they are usually accorded individual notice as though these three were distinct and separate conditions. In the attempt to carry out this classification in the individual case, however, the clinician at once encounters difficulties. In a large percentage of these cases—which may comprehensively be described as cases of "lung suppuration"—abscess formation, bronchiectasis and gangrene coexist, and it is not at all an easy matter to assign the predominating rôle to any one of them.

In order to make clear some of the more salient points in the pathology and etiology of these affections, it may be of value to analyze a series of 100 cases which came under my observation up to 1918.

In respect of their etiology, these cases may be classified as in Table 1.

TABLE 1.—CLASSIFICATION OF ONE HUNDRED CASES OF LUNG SUPPURATION ACCORDING TO THEIR ETIOLOGY

Etiology	No. of Cases
Postoperative:	
(a) Tonsillectomy	21
(b) Other operations	5
Postpneumonic	37
Insidious (colds, grip)	21
Postempyemic	3
Aspiration:	
(Submersion)	2
(During coma, drug and alcoholic)	2
(Foreign body)	2
Secondary to sinusitis	1
Tuberculous	2
Secondary to esophagus carcinoma	1
Actinomycotic	1
Diabetic	1
Syphilitic	1

If we analyze the various factors that were presumably responsible for the suppurative lung condition, they may be divided roughly into two groups: (1) those due to the aspiration of septic material into the bronchi, either during the course of operations, usually on the mouth, or in states of unconsciousness, however induced; and (2) the various primary lung inflammations, including both the frank pneumonias and the cases of so-called grip which undoubtedly represent unrecognized pneumonias.

These two groups will account for 94 per cent. of the cases. The rest are due to rare and miscellaneous causes. I have included no cases of metastatic lung abscess such as may occur in the course of sepsis, as they are uncommon and do not usually appear prominently in the clinical picture.

These two groups not only are distinct as to their causation, but they also show a divergence in their symptomatology and pathology. This, however, is evident only in their early stages; and in order to recognize these differences, it is necessary to observe them from their inception.

PATHOLOGY OF ASPIRATION ABSCESS

The frequency of suppuration of the lung after tonsillectomy, and its rarity after operations on other parts of the body, cannot fail to arrest attention. It is plausible to assume that it stands in some relation to the infected condition of the tonsils. It is probable that the infectious plugs which are expressed from the tonsils during the operation are forcibly aspirated into the bronchi, where they lodge. If a small amount of blood is aspirated with them, its coagulation will seal the bronchus and produce conditions favorable for the growth of anaerobic organisms. The abolition of the pharyngeal reflex appears to be necessary, as disease developed only in those cases in which a general anesthetic was administered. A similar mechanism will probably explain the few cases which followed profound unconsciousness due either to drugs or to alcohol.

The immediate result of the lodgment of such a mass of infectious material in a bronchus is to set up a localized bronchitis. Owing to the nature of the organisms, the process is destructive and gangrenous so that there soon results a weakening and dilatation of the bronchial wall. The initial process is therefore, strictly speaking, a localized bronchiectasis which soon invades the contiguous lung tissue. The examination of such lungs excised at operation will always reveal one or numerous such irregular cavities, which may be small and still show evidence in their walls of bronchial structure; or, on the other hand, the cavity may be large and all vestige of bronchus may be destroyed. Coincidently with the bronchial changes, the adjacent lung experiences the effects of the infectious material. A small or a large area of the lung about the necrotic focus, sometimes a whole lobe, becomes the seat of an acute or subacute pneumonitis, with consolidation. It is significant for the later course of these cases that the pneumonic process in many cases has from the beginning a tendency to organization, so that ultimately the lung undergoes induration. The latter, owing to the development of fibrous tissue about the smaller bronchi, compresses them and thus there are produced numerous small secondary bronchiectases. These secondary bronchiectases as a rule do not achieve a great size; most of them appear as bronchial dilatations only on microscopic section. On the other hand, they may be infected by the secretions of the primary bronchiectasis and breaking down, in their turn, they may terminate as larger cavities. This, in short, is the evolution of an abscess or bronchiectasis following aspiration.

It will be noted that this is primarily a bronchial disease, and in this sense may be described as a bronchiectasis. On the other hand, in all cases an abscess cavity sooner or later develops. But it must not be forgotten that a very important and essential element in the disease is a pneumonitis, which always accom-

panies it, and which, because of its tendency to induration, constitutes one of the main obstacles to its cure.

From the clinical standpoint, aspiration abscess of the lung is always an acute disease, although later it may assume a chronic form. A study of the chronology of the symptoms will show that the acuteness of the process stands in intimate relation to the development of a gangrenous type of inflammation. It is a striking fact that signs of gangrene, consisting of the expectoration of fetid sputum or of a foul odor to the breath, are invariably noted thirteen or fourteen days after operation. The same thing is true of nonoperative cases of aspiration abscess. It will therefore be seen that such cases have a definite incubation period which must stand in close relation to the biology of the infecting anaerobic bacteria. In fact, all the facts at our disposal point strongly to the presumption that postoperative and aspiration abscess or bronchiectasis is an acute anaerobic infection of the lung, which has a definite pathology and incubation period, the subsequent course of which is to a great extent dominated by the fluctuations in the intensity of the gangrenous process.

PATHOLOGY OF POSTPNEUMONIC ABSCESS

The pathology of so-called postpneumonic abscess is not at all as easily studied as the previous form. This is due, first, to its frequent insidious onset, and secondly, to the fact that under the term "postpneumonic abscess" a variety of diverse types of lung suppuration is included. If we analyze the fifty-eight cases of presumably postpneumonic suppuration which are the subject of this study, they may be divided roughly into two groups. In the first group there will be found sixteen cases in which the symptoms and other evidences of the disease, later to be discussed, differed in no wise from those in the aspiration cases. In these patients, the evidences of gangrene were always noted from thirteen to fourteen days after the onset. For reasons to be discussed later, the question will arise whether these are really cases of acute pneumonia on which a gangrenous process has been engrafted, or whether they are not primarily cases of lung gangrene and bronchiectasis. The remaining forty-two cases apparently have a different pathology. They commonly result from an attack of bronchopneumonia, which is frequently of the grip type. Instead of resolving in the normal way, the infiltration persists and acquires a fibrotic character with a resulting induration of the lung. As a result of pressure of the fibrous tissue on the smaller bronchioles, numerous cylindric bronchiectases develop. This is evidenced by persistent fever, cough, increasing expectoration and occasional hemoptysis. The entire process is slow and subacute, and it is months before the outspoken symptoms of lung abscess develop. The relation of gangrene to these cases is variable. In many cases it appears only late and may be only a transient manifestation. In a large percentage of the cases at some time during the course of the disease, the patient expectorates fetid sputum for a few days. But at any time, it may become a major factor, and by causing a rapid breaking down of the lung tissue it may convert a relatively benign case into one that is rapidly fatal.

LOCATION OF THE DISEASE

The distinction between these two groups of lung abscess or bronchiectasis may be further noted in the distribution of the inflammatory process in the lungs. Postoperative and aspiration abscesses are found twice as often in the upper lobes as in the lower lobes. Exactly the reverse condition obtains in the case of postpneumonic abscess of the chronic type. This is well brought out in the tabulation of ninety-nine cases presented in Table 2.

TABLE 2.—DISTRIBUTION OF INFLAMMATORY PROCESS IN LUNGS

Kind of Abscess	Location		
	Upper Lobe	Lower Lobe	Middle Lobe
Aspiration abscess	18	9	1
Nonaspiration abscess	24	44	3

A separate consideration of the cases of acute postpneumonic abscess with early gangrene shows that in these cases also the upper lobes are involved more frequently than in the chronic postpneumonic cases. It is of interest to note that in the children in this series, postoperative abscess invariably was situated in the upper lobes.

SYMPTOMS AND PHYSICAL SIGNS

In the case of aspiration abscess, the characteristic symptom is the onset after two weeks of foul expectoration. It is evident in these cases that the development of this symptom after an operation will leave no doubt as to the diagnosis. This is true also of the acute postpneumonic abscesses. On the other hand, a cough persisting for some time after a pneumonia, especially if there is only a moderate purulent expectoration, does not warrant the diagnosis of bronchiectasis. In these cases the diagnosis must usually remain in doubt for some months, until the more characteristic symptoms develop. These patients commonly have a persistent fever, and usually slight hemoptysis, which will raise a strong suspicion of an indurative pneumonia. Only the later development of multiple bronchial dilatations, with profuse expectoration, will lend certainty to the previous suspicion. The distinction from tuberculosis should offer no difficulty because of the absence of tubercle bacilli, but especially because of the usual localization of the condition in the lower lobe. The presence of club fingers, which occurred in twelve cases, may be of help in the diagnosis. They develop relatively early in the course of bronchiectasis, at times as early as six weeks, although usually in a few months. On the other hand, clubbing develops only in long standing cases of pulmonary tuberculosis.

It is a fortunate circumstance that the diagnosis of suppuration of the lung may be so readily made from the symptoms, as the physical signs are notoriously uncertain. The physical diagnosis must depend on the demonstration of an area of infiltration in the lung, and also, in some cases, on the disclosure of a cavity. It is surprising how few signs even a large pneumonic area may produce. Usually only a slight dulness and diminished breathing are found. At times, there may be absolutely no physical signs. In this series of 100 cases, a cavity was diagnosed only twelve times by physical examination, although roentgenographic examination showed them to be present in forty-five cases. For an exact localization of the process, to determine the extent of the disease, and to ascertain the presence of cavities, we are to a great extent dependent on the roentgenogram.

It should be emphasized that in the diagnosis of suppuration of the lung, the demonstration of one or multiple cavities is not at all essential, nor is it possible in more than a fair percentage of the cases. When cavities are buried in infiltrated lung, when they are full of secretion, and when they are small, they will elude any kind of examination. Only the larger cavities are usually discovered. These are much more frequent in the postoperative cases and in the acute postpneumonic cases. In other words, in those cases in which the gangrenous process plays a major rôle, large cavities are early formed. Their frequency is indicated in Table 3.

TABLE 3.—FREQUENCY OF LARGE CAVITIES IN POST-OPERATIVE AND POSTPNEUMONIC CASES

Case	Cavity	No Cavity
Aspiration abscess	21	3
Acute postpneumonic abscess	16	0
Chronic postpneumonic abscess	13	30

COURSE AND PROGNOSIS

The etiology of lung abscess has a decisive influence on its course and prognosis. The prognosis is best in the postoperative cases. Of these, nine patients recovered spontaneously, eight of them being posttonsillectomy cases. In the process of cure, it is remarkable that even large cavities may disappear in a very short time. The necrotic wall of the cavity sloughs out and is expectorated, and as the surrounding pneumonia undergoes resolution, the lung once more expands and obliterates the cavity. The cure of postoperative abscess was accomplished in every case within two months of the onset. Cases which persisted beyond this time invariably went on to a chronic stage, with a resulting lung induration, and later developed the usual sequelae and complications.

The disappearance of all symptoms and physical signs in a case of lung abscess should not without more ado be regarded as decisive evidence of its cure. This disease is characterized by deceptive remissions during its early stages which necessitates great caution in the prognosis. A large percentage of the acute postoperative cases, after a few weeks, become quiescent or nearly so. In these cases a roentgenographic examination will usually reveal a small area of infiltration which is below the threshold of physical examination. Sooner or later, this remnant of the disease will be stirred to activity, and the symptoms of a gangrenous abscess will be reproduced. The disease will then take its course for months or years until it is terminated by any one of a number of complications which continually menace these patients. Among these, pulmonary hemorrhages should be first mentioned. Hemoptysis in lung abscess occurs more commonly than it does in pulmonary tuberculosis, and not infrequently it is fatal. In a few cases a superficial abscess has ruptured into the pleura with a resulting pyopneumothorax. More commonly a simple empyema develops. In three cases, septic embolism of the brain caused the death of the patient. In addition there are periodic exacerbations in the severity of the symptoms which are probably due to an extension of the inflammatory process. This may occur slowly or may develop rapidly, owing to the spilling over of the contents of a cavity into previously uninvolved portions of the lung.

The prognosis of the postpneumonic cases appears to be almost absolutely bad; but two patients recovered in this series, although the case of one of these is doubtful, at least, as he died subsequently of brain abscess. The perforation of a superficial abscess in postinfluenzal cases in their early stage appears to be a favorable occurrence. Three patients, observed last year, in which this complication occurred, recovered promptly after drainage of the pleural cavity. It appears probable that the rupture of the cavity into the pleura served the purpose of pulmonary drainage, which apparently may be an effectual method of cure before the lung has become indurated.

Most of the postpneumonic cases continue until there is a progressive induration of the lung with the formation of multiple bronchiectases. Unless the condition is fatally terminated by one of several complications, the patients may live for years. Their lot, however, is sad and hopeless. Usually, the course of the disease is punctuated by periods of aggravation of the symptoms, in which the patients are harassed by a constant cough, profuse expectoration, which is often so fetid as to require their isolation, and attacks of high fever. On the other hand, there are cases in which the patients enjoy a considerable degree of comfort for many years, their only symptom being a copious purulent expectoration which is evacuated every morning on arising. They may have no fever, and there is usually no gangrene. These cases usually date from childhood, and may result from an attack of bronchopneumonia. In these cases the disease may be purely a bronchial one, the lung parenchyma being not at all involved. The roentgenogram reveals multiple globular dilatations of the bronchi, usually of a lower lobe, so that the lung has a spongy or honeycomb appearance. It is evident that the prognosis for the life of the patient in this type of case is fairly good, although a cure cannot be expected.

TREATMENT

The medical treatment of suppurative lung disease offers little that is encouraging. It can be only symptomatic. The disease responds favorably for a time to climatic treatment; but there is sooner or later a recurrence of the symptoms. Symptomatically, the relief of the cough is an important object to accomplish. Constant violent coughing, by projecting the infectious material farther down into the smaller bronchi, undoubtedly disseminates the disease, and also promotes the formation of bronchiectases by weakening the bronchial walls. Periodic upsetting of the patients will facilitate drainage. Irrigation of the bronchi through the bronchoscope accomplishes the same purpose and may also keep the anaerobic process in check so that the expectoration is less offensive. This procedure cannot, however, cure these patients, as it has no effect on the pulmonary infiltration.

OPERATIVE TREATMENT

Acute lung abscess or gangrene is usually not an operative condition. A study of the cases here recorded has shown that at least one third of the patients with aspiration abscesses recover spontaneously usually within a period of two months. For this reason any operative procedure for the cure or relief of lung suppuration may profitably be postponed for several months. Two types of operation may be applied to these cases: thoracotomy with drainage, and lobectomy of one or more lobes of the lung.

Thoracotomy can at best be but a palliative procedure. By supplying drainage of the cavities, it diverts their secretion from the upper respiratory tract, thus, to some extent, shielding uninvolved portions of the lung from infection. It may produce a distinct improvement in the condition of the patient. A knowledge of the pathology of lung suppuration teaches us, however, that the only hope of complete cure rests in a complete removal of the infiltrated lung. This, no drainage operation can accomplish. Unfortunately, lung resection is an operation fraught with the greatest difficulties; it demands the highest surgical skill, and the operative indications in the individual case are extremely narrow. They may thus be formulated: The patients must be young: the operation in those who have reached the age of 40 has a prohibitive mortality. The case must be uncomplicated, that is, the pleural cavity must be free of dense adhesions so that the lobectomy may be expeditiously performed. Operations which last much over an hour result in a high mortality. The disease must be unilateral. When the operation has been successfully performed, the patient is completely cured; and surgery records no more brilliant or dramatic achievement than the restoration to health of a person afflicted with this most dreadful and hopeless disease. Of the patients in this series, five were cured by lobectomy by Dr. Lilienthal, all of whom remain well to this day.

Of the other surgical procedures, mention should be made of artificial pneumothorax. It is difficult to see how the injection of air into the pleural cavity may be expected to cure these patients. The conditions present bear no similarity to those which obtain in tuberculosis. It is not desirable to stimulate fibrosis, as there is already a tendency to fibrosis. The collapse of a cavity, if this is possible, which is doubtful, will not bring about the removal of a gangrenous focus. Not only is this procedure of no value, but it also may be distinctly harmful. The collapse of the lung may lead to a dissemination of septic material into distant portions of the lung with a rapid extension of the disease. In two of the cases in this series in which artificial pneumothorax was performed, not only was there a marked extension of the disease, to be observed on the roentgenogram, but also both patients died suddenly, shortly after the last insufflation.

It is important to emphasize the value of bronchoscopic examination preliminary to any operative procedure. In children, especially, it is not unusual to find a foreign body in the bronchus as the unsuspected cause of a lung abscess, and unless the disease is of long standing, removal of the foreign body may result in a cure.

CONCLUSION

It may be worth while to emphasize a few points in the pathogenesis of suppuration of the lung. There seems to be little doubt, from a study of the cases of postoperative abscess, that the disease is bronchogenic. It is equally probable that the infection is primarily gangrenous and owes its origin to definite forms of anaerobic micro-organisms. The pathogenesis of postpneumonic abscess is, however, not so clear. In the chronic types there is, undoubtedly, primarily a pneumonic process which is due to the usual bacteria, such as the streptococcus and pneumococcus, which have the power to incite a chronic type of inflammation. There is, however, a group of so-called acute postpneumonic abscesses or gangrene in which, without any evidence of operation or aspiration, there is, nevertheless, a primary gangrenous inflammation. In these cases, of which there were sixteen, the onset of fetid expectoration occurred on the thirteenth or fourteenth day just as in the cases of aspiration. They resembled the latter also in the frequent involvement of the upper lobes and in the early development of large cavities. The question, therefore, arises whether these are truly cases of pneumonia with subsequent development of gangrene, or whether they are not also due to the aspiration of septic material from the teeth or the tonsils, perhaps in the act of snoring during sleep. That this is not improbable will be evident from a consideration of several of the cases in which aspiration gangrene developed during unconscious states. This occurred in one case after an overdose of morphin, and in another after alcoholic coma. In both these cases, the chronology of the symptoms and the clinical course were identical with those of postoperative cases. It is to be hoped that a clearer insight into the pathogenesis of lung suppuration will be obtained when we succeed in reproducing the disease in animals, and when systematic studies of its anaerobic bacteriology have been made.

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CONTAMINATION OF THE HANDS AND OTHER OBJECTS IN THE SPREAD OF DIPHTHERIA

OBSERVATIONS ON SECONDARY INFECTIONS IN HOSPITALS FOR CONTAGIOUS DISEASES *

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Crossed infections in hospitals for contagious diseases are always a matter of concern, and the technic followed in modern hospitals for these diseases has been elaborated with the special purpose of preventing such infections. Since the transfer of the infectious material is probably in most cases by direct carriage, it is most important to know just what the carrier is and to take measures to avoid its activity. It is readily imagined that the hands of nurses and others which are often in contact with patients and which frequently become contaminated by discharges from the throat, nose, ears, etc., may readily act as carriers. Our observations were made to learn if the routine followed in the hospital was sufficient to preclude such carriage by hands. Cultures were made to determine whether the hands of nurses and interns were free from the organisms which they had acquired in handling patients after the washing with soap and running warm water which we have depended on for cleaning the hands. The observations were made on a floor of the hospital principally devoted to diphtheria patients. Two forms of bacteria were sought by cultures, namely, the diphtheria bacillus and hemolyzing streptococcus. Neither of these is apt to occur except as it comes from disease secretions. Davis[1] and others have

* From the Durand Hospital of the John McCormick Institute for Infectious Diseases.

1. Davis, D. J.: Illinois M. J. 36: 134 (Sept.) 1919.

pointed out that hemolyzing streptococci do not occur on normal clean skin. Since they commonly are present in the secretions in cases of diphtheria, their presence on the hands of those caring for persons with this disease can safely be inferred to be due to contamination with patients' secretions. Similar conditions apply to diphtheria bacilli. Cultures were also made from door knobs leading to the vestibule of patients' rooms, since if they become contaminated they may soil hands that have been properly cleaned. The cultures from hands were taken after routine washing, the person not knowing when they were to be taken. Cultures from door knobs were made after they had been unwashed for several hours.

The material for cultures was secured by drawing sterile cotton swabs, moistened with sterile water, beneath the nail of the right index finger, over the palmar surface of the same finger, and over the surface of a door knob. The swabs were rubbed over slants of Loeffler's solidified blood serum, and then washed off in sterile broth from which 5 to 10 drops were used in preparing blood agar plates. When organisms resembling diphtheria bacilli were seen in preparations from the culture on Loeffler's serum, pure cultures were isolated. Only those were finally recognized as diphtheria bacilli which produced typical lesions in guinea-pigs and were protected against by diphtheria antitoxin. In the blood agar plates, minute hemolyzing colonies were transferred to broth, and those strains which grew in chains and which produced a wide zone of hemolysis on a blood agar streak were listed as hemolyzing streptococci. The observations were carried out over a period of five months. The results may be thus summarized:

RESULTS OF EXAMINATIONS

A total of 268 examinations were made on forty-five pupil nurses, from one to fifteen examinations being made on the same individual. Of the 268 cultures from beneath the nail and from the palmar surface of the right index finger, twenty-five, or 9.3 per cent., contained hemolyzing streptococci and eight, or 3.0 per cent., diphtheria bacilli. Of the forty-five nurses, sixteen, or 35.6 per cent., yielded hemolyzing streptococci, twelve from beneath the nail, two from the palmar surface of the finger, and two from both locations. Of the same nurses, six, or 13.3 per cent., yielded diphtheria bacilli, three from beneath the nail, two from the palmar surface of the finger, and one from both locations. No individual who had ten or more cultures failed to show hemolyzing streptococci.

Similar examinations were made of four graduate nurses who had been specially trained in the care of contagious diseases, from five to twenty cultures being made on single individuals. In fifty-one cultures, hemolyzing streptococci were found but once, that is, in about 2 per cent. Diphtheria bacilli were never found. These nurses work with the sickest patients, and their hands are especially liable to contamination. The contrast between the results in highly trained and pupil nurses is striking.

From the hands of three interns, forty-five cultures were made, seven of which, or 15.6 per cent., yielded hemolyzing streptococci, and three, or 6.7 per cent., diphtheria bacilli. Each of the three interns yielded diphtheria bacilli from beneath the nail on one occasion. In two of these the cultures were taken immediately after scrubbing the hands following the making of a necropsy in a case of diphtheria during which no rubber gloves were worn. All of their hemolyzing streptococci were from beneath the nail.

Cultures were taken from the hands of four diet maids. Out of sixty-four cultures, hemolyzing streptococci were found beneath the nail twice, or in 3.1 per cent. No diphtheria bacilli were found.

An orderly who handled the laundry bags and waste materials yielded hemolyzing streptococci from beneath the nail four times out of eighteen cultures, but never diphtheria bacilli. Cultures from persons in the hospital office and laundry were uniformly negative.

Cultures were made from door knobs 137 times, eight, or 5.8 per cent., yielding hemolyzing streptococci, and six, or 4.4 per cent., diphtheria bacilli.

METHODS OF AVOIDING CROSS INFECTIONS

The significance of these findings is evident. While the streptococci may not always have come direct from patients, this can hardly be the case with diphtheria bacilli. It is evident that washing with soap and warm running water as carried out by most individuals does not entirely rid the hands of pathogenic bacteria. That it can be done, however, is indicated by the result of cultures from the hands of the specially trained nurse. The soiling of door knobs, etc., by unclean hands furnishes a means for contamination of clean hands, and so one careless person may annul the efforts of others. It would seem necessary to give special detailed instruction in the care and cleansing of the hands, especially of the nails, to all pupil nurses and interns when they begin work in a hospital for contagious diseases. They should be taught to avoid needless soiling of the hands as well as proper cleansing. They should be impressed by the great danger of the hands acting as carriers of infection to patients and to themselves.

In caring for patients when gross contamination of the hands cannot be avoided, and when performing necropsies, the difficulty of complete cleansing would suggest the use of some mechanical protection, such as rubber gloves. The routine making of cultures such as we have indicated, and which we propose to continue, might well be of value as a check on the technic of persons working about contagious diseases. Doors so constructed that knobs are eliminated would remove one means of hand contamination.

Even with the most perfect mechanical conditions, instances of cross infection can be eliminated only by intelligent, conscientious care by every person who has to do with the patients. Those who are careless should not be tolerated about hospitals for contagious diseases.

Fight Against Hookworm.—The annual report of the International Health Record of the Rockefeller Foundation states that Brazil, Central America, the West Indies, and Far East, and twelve states in the United States are enlisted in cooperative work in the campaign against hookworm. Requests for aid in combating the disease were received from Colombia, the Barbados, Curaçao, and Santo Domingo, West Indies, the Madras Presidency, India, Kelantan, and the Federated Malay States, and Mauritius. In the United States, Alabama, Arkansas, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas and Virginia were added to the states actively engaged against the disease. In the West Indies, Guiana, St. Lucia, St. Vincent and Trinidad; in Central America, Costa Rica, Guatemala, Nicaragua, Panama and Salvador; in the Far East, Ceylon, China, Fiji, Seychelles, Siam and Queensland, Australia and in Brazil, the federal district of São Paulo, and Rio de Janeiro.

ASYNCHRONISM OF THE RESPIRATORY MOVEMENTS IN LOBAR PNEUMONIA*

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The type of breathing to be described first attracted my attention some twenty-five years ago. Subsequently, it was observed with such constancy that I simply assumed it to be well known. A recent review of the literature, however, which included the more recent textbooks, various systematic discussions of lobar pneumonia, and all of the suggestive titles in the second edition of the Surgeon General's Catalogue yielded only two references to the subject. Grocco[1] gave a brief description of the phenomenon in 1904. Frugoni,[2] his pupil, included it in an extended study of pathologic changes in the respiratory rhythm in 1910.

In 1904, Hughlings Jackson[3] reported an isolated case of "latent pneumonia" in which there were no contractions of the intercostal muscles with ordinary breathing. The rate of the respiration was 44 per minute. The intercostals acted, however, when the patient was told sharply, "Breathe!" "There was loss of automatic movement of the intercostals with persistence of the voluntary movement of the same muscles." The diaphragm appeared not to act in the "voluntary" breathing since the epigastrium sank in. This case only remotely resembles the type of breathing under discussion. Jackson himself thought that the phenomenon was due to a circumscribed myelitis of the lateral horns, if not more, of the cord.

Asynchronism of the respiratory movements is characterized by a separation of the moment of contraction of the diaphragm and intercostal (and other thoracic) muscles by a definite, though variable, time interval. As far as my observations go, the diaphragm always contracts first; the abdominal wall is forced outward, and then, after varying intervals, the contractions of the intercostal muscles follow. Careful attention may be necessary to detect the lag in the movement of the thorax; the lowermost intercostals may contract first and the movement of the thorax spread from below upward, or the delay in the contraction of the intercostals may result in complete asynchronism. In the fully developed type of asynchronism, the diaphragm reaches the expiratory phase before the contractions of the intercostals set in, and the abdomen and chest rise and fall alternately—"see-saw" best describes the impression conveyed. The time relations of the contractions of the diaphragm and intercostal muscles with those of the auxiliary and associated respiratory muscles (for example, dilatation of the alae nasi) have not yet been determined in detail, but dilatation of the alae nasi has been observed to precede the bulging of the abdomen, which in turn preceded the movement of the thorax.

INCIDENCE

Grocco states that he has observed asynchronism of the respiratory movements in meningitis (especially the basilar form), typhus fever, pneumonia, heart disease, uremia, and cerebral abscess, hemorrhage, or tumors. In my experience, a slight delay in the contractions of the intercostal muscles has occurred in uremic stupor, pulmonary abscess following pneumonia, and in cases of indefinite febrile disease; but complete asynchronism has occurred only in lobar pneumonia.

PROBABLE CAUSE AND PROGNOSTIC SIGNIFICANCE

Asynchronous breathing possesses especial interest from two standpoints: (1) its probable cause, and (2) its prognostic significance.

1. *The Cause of Asynchronous Breathing.*—The search for the cause of asynchronous breathing has suggested that the phenomenon may help to clear up problems in the physiology of respiration which have not yet been solved. For example, the time relations of the contractions of the various respiratory muscles and groups of muscles have not yet been determined with certainty, nor have the identity and respective functions of the different parts of the central nervous system concerned in the regulation of the respiratory movements.

In 1849, Hutchinson[4] described the normal respiratory movements:

> In ordinary male breathing in man the abdomen first bulges outward; the ribs and sternum nearest the abdomen gently follow this movement until the motion, like a wave, is lost over the thoracic region. In costal breathing, the upper ribs move first, and the abdomen, second. This is the ordinary breathing in women.

Without a definite statement to that effect, Keith[5] conveys the impression that he believes the inspiratory muscles act in unison. He found that if tracings are taken over the epigastrium and over the apex of the lung, the descent of the diaphragm precedes that of the apex; but he explains this on the ground that for anatomic reasons the apex cannot expand unless the lung descends, and that the downward piston-like thrust of the diaphragm causes the lowermost part of the lung to expand first.

In Dally's[6] discussion of Keith's paper, he states definitely that reciprocal exciting and inhibitory impulses control the action of at least some of the muscles of respiration:

> As Sherrington has shown in case of the limbs that contraction of the flexor muscle group can only take place by temporary corresponding inhibition of the extensor group, and vice versa; so during respiration I believe the diaphragm in its active downward contraction to be synergic with the powerful muscle group which produces extension of the vertebral column, whilst in expiration it is antergic to the muscles of the abdomen.

Howell[7] states that "the inspiration in man (in quiet breathing) is made by the diaphragm alone or by the diaphragm together with some action of the levatores costorum and the external intercostals."

Luciani[8] states that in sleep respiration is essentially costal, the diaphragm is virtually inactive; sometimes the thoracic respiration precedes the diaphragmatic;

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* A preliminary report was made in the Proceedings of the Society of Experimental Biology and Medicine, 15:92, 1918.
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1. Grocco: Riv. crit. di clin. med. 5:333, 1904.
2. Frugoni: Policlinico, sez. med. 17:312, 1910.
3. Jackson, J. H.: Lancet 2:1472, 1894.
4. Hutchinson: Thorax, Todd's Cyclopaedia of Anatomy and Physiology, 1849, p. 1080.
5. Keith: Brit. M. J. 2:589, 1908.
6. Dally: Brit. Med. J. 2:592, 1908.
7. Howell, W. H.: A Text-Book of Physiology, Ed. 7, Philadelphia, W. B. Saunders Company, 1918, p. 653.
8. Luciani, Luigi: Human Physiology, New York, Macmillan Company, 1911.

and that in the death agony only the diaphragm is active, while the intercostal muscles are paralyzed.

Also, according to Luciani, the immediate centers for the respiratory nerves are in the gray matter of the cord; they depend on the controlling center in the bulb —formatio reticularis—which is probably under cerebral control. Mosso[9] believes there are at least a facial, a thoracic and a diaphragmatic center for inspiration.

In discussing the question of the existence of more than one respiratory center, Luciani asks, "Do the various modes of functional association and succession of the several muscles or groups of respiratory muscles depend exclusively on the bulbar center; or do the respective spinal centers cooperate actively; or is the varying degree of excitability of these centers at the given moment when they receive impulses from the bulbar center, of account?" He does not give the answers; but the questions themselves evidently express his belief that under certain conditions the coordination of the different muscles may be disrupted.

If Hutchinson's views and the similar views of Luciani and Howell are correct, the delay in the contractions of the intercostal muscles in lobar pneumonia is merely an exaggeration of the normal dissociation. On the other hand, if the contractions of the respiratory muscles are controlled, as Dally suggests, by reciprocal exciting and inhibitory impulses, asynchronism indicates a more or less profound disturbance of the nervous control of respiration.

In this connection it will be of interest to inquire to what extent respiration in pneumonia can be brought into relation with the control of the respiratory mechanism in health.

Haldane[10] and his associates have shown that the discharge of impulses from the respiratory center is regulated (among other factors) by the carbon dioxid pressure in the blood and alveolar air. The reaction of the center is so delicately adjusted that fractional alterations of the carbon dioxid pressure in the alveolar air and blood call forth marked responses (an increase of 0.2 per cent. carbon dioxid in the alveolar air doubles the breathing, a fall of 0.2 per cent. causes the breathing to cease). In order, however, that the carbon dioxid may be effective, the oxygen pressure must be maintained at a definite (but relatively low) level.

Peabody[11] found that the carbon dioxid content of venous blood in pneumonia is constantly diminished and that the ammonia of the urine runs parallel with it. While the carbon dioxid content bears little relation to the severity of the disease, it tends to be lower in the more severe cases. In two unusual cases ,the carbon dioxid content was normal or above normal. In view of the higher rate of metabolism in pneumonia with increased production of carbon dioxid, the diminution of the carbon dioxid content of the blood can only be explained by diminished carrying power of the blood or by its more rapid elimination through the lungs. Peabody[12] also found that the oxygen content of venous blood in pneumonia was within normal limits except in the terminal stages of fatal cases, when a progressive decrease occurs.

An interesting suggestion may be drawn from Peabody's observations, namely, that one of the modes of death in pneumonia may be in reality the result of excessive reduction of the carbon dioxid in the blood (acapnia) with so great a fall of venous blood pressure (venodepressor effect of Yandell Henderson[13]) that sufficient blood is removed from active circulation (as in hemorrhage) to precipitate the fatal issue.

Peabody's results make it clear that the cause of the rapid breathing of pneumonia must be sought in other factors than the carbon dioxid and oxygen pressures of the blood.[14]

Porter[15] and his associates have studied the functional state of the respiratory center in experimental pneumonia (produced by Friedländer's bacillus) in dogs by measuring its reaction to increasing percentages of carbon dioxid in the inspired air. They found that the center was progressively depressed as the disease advanced. In view of the fact that the center was not depressed in bacteremias produced by the same organism, they concluded that the depression was not due to the action of the toxin of the bacillus on the nerve cells of the center. Similarly, by allowing the animals to breathe pure oxygen they eliminated lack of oxygen as the cause. Since section of the vagus nerves prevents depression of the respiratory center, they concluded that the depression was due to exhaustion of the center by afferent impulses from the inflamed lung. These results are suggestive, but they should be applied to pneumonia in man, caused by a different group of organisms, with caution.

It is generally believed by clinicians that the respiratory center is depressed in pneumonia; and this opinion is supported by the action of morphin in the disease. In 1890, Loewy[16] found that morphin raises the carbon dioxid threshold of the respiratory center in man. These experiments have been repeated and confirmed a number of times for both man and lower animals. Henderson and Scarbrough[17] confirmed experimentally what has long been known clinically, namely, that the carbon dioxid threshold of the respiratory center is raised by morphin to a greater extent than the afferent threshold; in other words, respiration in opium poisoning may be maintained therapeutically by afferent impulses (vigorous flagellation, etc.).

The available evidence appears to justify the belief that the respiratory center is depressed in pneumonia; but whether the depression is caused by direct action of the pneumococcus toxin on the nerve cells, or by afferent impulses from the inflamed lung, or both, must remain open questions for the present.

The complete dissociation of the contractions of the diaphragm and intercostal muscles (the one being in the inspiratory phase, while the other is in the expira-

9. Mosso, cited by Luciani (Footnote 8).
10. Haldane, J. S.: Organism and Environment as Illustrated by the Physiology of Breathing, New Haven, Yale University Press, 1917.
11. Peabody, F. W.: The Carbon Dioxide Content of the Blood in Pneumonia, J. Exper. M. **16**: 701, 1912.
12. Peabody, F. W.: The Oxygen Content of the Blood in Lobar Pneumonia, J. Exper. M. **18**: 7, 1913.
13. Henderson, Yandell, and Harvey, S. C.: Am. J. Physiol. **46**: 533 (Aug.) 1918.
14. Since this article was written, Stadie's work on the oxygen content of arterial and venous blood in pneumonia has appeared (Stadie, W. C.: J. Exper. M. **30**: 215 [Sept.] 1919) in which it was found that a decided reduction in the oxygen content of both arterial and venous blood occurred, especially in fatal cases of pneumonia. The average "unsaturation" (oxygen content as contrasted with oxygen capacity) of arterial blood of four patients with lobar pneumonia who recovered was 10 per cent., of venous blood 44.2 per cent.; in three fatal cases, the averages were 27.6 per cent. for arterial and 59.5 per cent. for venous blood. (The normal figures are 5 per cent. and 26.8 per cent., respectively.) In the light of Stadie's results and those of Haldane, Meakins and Priestley (The Respiratory Response to Anoxemia, J. Physiol. **52**: 420, 1919; The Effects of Shallow Breathing, ibid., p. 433), the conclusion appears warranted that the increased rate of respiration in pneumonia is due chiefly, if not entirely, to deficiency of oxygen.
15. Porter, W. T., and Newburgh, L. H.: Am. J. Physiol. **42**: 175 (Dec.) 1916. Other references will be found here. Newburgh, L. H.; Means, J. H., and Porter, W. T.: Boston M. & S. J. **174**: 484 (March 30) 1916.
16. Loewy: Arch. f. d. ges. Physiol. **47**: 601, 1890.
17. Henderson, Yandell, and Scarbrough, M. M.: Am. J. Physiol. **36**: 260, 1910.

tory) makes it apparent that the central nervous mechanism is unequally affected. But whether the depression is confined to the bulbar center (formatio reticularis), or affects the other centers as well cannot at present be determined. When it is recalled that the facial, abdominal and costal movements may all occur asynchronously, strength is added to Mosso's belief that a facial, a diaphragmatic and a thoracic center for inspiration exist.

2. *Prognostic Significance.*—Asynchronous breathing was first observed in patients with lobar pneumonia who were dangerously ill and who required constant attention throughout the night. As opportunity for wider observation came, it was found to occur only in the severest cases. Without having kept statistical records, I can recall only a few patients exhibiting the phenomenon, at least in a well developed form, who recovered. It usually develops late in the disease, but it may appear within the first few days, and give the first intimation of the gravity of the case. After long observation I have come to regard asynchronism as a sign of the gravest import. While patients who develop it generally die, it does not occur in all fatal cases. In the influenzal pneumonias of the recent epidemic, asynchronous breathing was comparatively uncommon in my experience.

SUMMARY

Asynchronous contractions of the respiratory muscles occur in many cases of lobar pneumonia. In the fully developed type of asynchronous breathing, the diaphragm and thoracic respiratory muscles contract alternately, with the result that the abdomen and the chest "see-saw" up and down.

The cause of the phenomenon probably lies in unequal depression of different parts of the central nervous respiratory mechanism.

The development of asynchronous breathing usually augurs a fatal termination.

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EOSINOPHILOUS MYOCARDITIS IN DIPHTHERIA

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The presence of eosinophils in the myocardium was first noted by Straubli[1] in a guinea-pig with trichosis. Rindfleisch[2] also recorded the condition in an acute interstitial myocarditis. Freund[3] found eosinophil cells throughout the myocardium in high-grade blood eosinophilia following teniasis. And Wulffius,[4] Tanaka[5] and Liebman[6] have described eosinophils in the myocardium after death from diphtheria.

So far as I know, recorded examples of eosinophil myocarditis are not described in American literature. The opportunity to obtain material from the Durand Hospital of the John McCormick Institute for Infectious Diseases prompted me to search for these cells in the myocardium after death from acute infection.

In sections from various parts of the auricles, ventricles and the papillary muscles, stained with various blood dyes, eosinophils were found in seven of twenty-nine hearts of children that had died of diphtheria. I did not find eosinophil cells in the myocardium of patients that had died of various other diseases, including scarlet fever, meningitis, poliomyelitis, measles, etc.

The cells were polymorphonuclear in type with many sharply stained granules. They were so prominent in sections stained with Wright's stain as to be detected easily on glancing over the field with low power. They usually occurred in groups of from four to twelve. In one instance, sixteen were noted in one field. The cells were grouped about among the individual muscle fibers and the connective tissue stroma. They were not more frequent in the hearts showing the most pronounced degenerative changes. So far as I could determine, the myocardial eosinophilia had no relation to the severity of the clinical symptoms or to the degrees of myocarditis or the amount of serum used in treatment. The average dose of serum in our patients was 22,000 units, or about 25 c.c., with a maximum of 110,000 and the minimum 4,000. The cells were never found in the structures which make up the specific conducting system of the heart, that is, the sinus node, Tawara's node, the His bundle, and the Purkinje fibers.

In my instances of eosinophilous myocarditis, the myocardial changes characteristic of diphtheria were present, but in no wise were they different from such cases in which eosinophils were not found. In all of the hearts studied, the myocardial changes were most pronounced about the blood vessels. Vacuolization of the muscle fibers, cloudy swelling, hyperemia of the small vessels, and blood extravasation between the muscle fibers and about the capillaries were regularly present. Fragmentation was not noted. Such changes have been described many times, more recently by Aviragnet and others.[7]

I have studied serial sections of the sinus node, Tawara's node, the His bundle, and the Purkinje fibers to determine whether changes of the special impulse conducting system of the heart might be made responsible for the various disturbances of rhythm so frequently noted clinically. In one heart, marked extravasation of the blood was found in the His bundle. In the others there were varying degrees of cloudy swelling of the individual fibers of the His bundle. Statements sometimes made to the effect that the fibers of the His bundle are enlarged as a result of cloudy swelling, etc., are rather indefinite, and depend in a large degree on the interpreter. After study of several dozen His bundles and the related structures which go to make up the special impulse conducting system of the heart, the changes found in this group of diphtheria hearts are not considered striking. But, since the His bundle is surrounded by a firm and dense connective tissue sheath, in some species, especially the sheep, this sheath often being cartilaginous, it is possible that even slight swelling of the individual fibers of the bundle might result in an increase of pressure within the bundle of sufficient degree to inhibit the passage of impulses. This compression, with possible changes within the fibers themselves, may be responsible for arrhythmias. This affords a satisfactory explanation for the instances of heart block that occur in diphtheria. Extrasystoles are noted less frequently. Auricular fibrillation following heart block in diphtheria has been recorded only once, so far as I know.[8]

1. Straubli: Trichinose, p. 206.
2. Rindfleisch: Dissertation, 1898.
3. Freund: Berl. klin. Wchnschr. **49**: 50, 1898.
4. Wulffius, J.: Frankfurter Ztschr. f. Path. **16**: 58.
5. Tanaka: Virchows Arch. f. path. Anat. **210**: 119, 1912.
6. Liebman: Deutsch. Arch. f. klin. Med. **117**: 438, 1915.
7. Aviragnet, E.-C.; Lutembacher, R., and Le Soudier: Arch. d. mal. du coeur **11**: 241 (June) 1918.
8. Parkinson, J.: Heart **6**: 13, 1915.

It is held that diphtheria toxin is responsible for the myocardial changes in diphtheria. Hume and Clegg[9] are said to have demonstrated that the toxin has a direct action on the bundle of His, causing both interstitial and parenchymatous changes. It is reasonable to suppose that the changes I have observed in the His bundle are due to the toxin.

Electrocardiograms were not made in the cases from which my material was obtained. However, the clinical charts of the patients show marked variations in the pulse rate from time to time, and frequently marked irregularity. The hospital cared for 805 diphtheria patients during the time that I obtained my material, and of this number ninety-three, or 11.6 per cent., died. However, in 6 per cent. of the fatal cases, the patients were moribund on admission and died within twenty-four hours. The hearts I studied were about equally divided between the group of patients that died soon after admission and the group that died after several days of observation. In each instance, the anatomic diagnosis began with the item tonsillitis, acute diphtheric pharyngitis or laryngitis, etc. Frequently, acute nephritis, myocarditis, and bronchopneumonia were noted also in the record.

The degree of myocarditis varied materially in the different specimens. It was most marked in the very toxic cases in which little antitoxin had been used. It is interesting to note that in one case in which 110,000 units (about 250 c.c. of serum) were given, the myocarditis was moderate and no eosinophils were present.

There are at least three possible explanations of the disturbance of the pulse rate in diphtheria: The degenerative changes in the myocardium due to the diphtheria toxin may cause it; similar changes in the nerve plexuses, the nerve fibers and endings in the heart may be responsible; or changes in the terminal fibers of this system, as the Purkinje fibers at the point where they fuse with the individual muscle cells of the myocardium, may cause it. When heart block occurs, involvement of the His bundle is certainly present. In other instances, myocardial, nerve and bundle lesions may be associated, and each may be partially responsible.

Several explanations of eosinophilous myocarditis in diphtheria have been offered. Schlecht and Schwenker[10] suggest that anaphylactic reactions play a rôle and that serum therapy increases its occurrence. Kulb[11] records an instance of severe myocarditis following the injection of 40,000 units of antitoxin. However, eosinophilous myocarditis does not seem to have been produced experimentally with serum poisoning, although it has been caused by epinephrin (adrenalin) poisoning.[12] Tanaka, who found this condition in four of fifteen diphtheria hearts, regards it as a symptom of subacute infection, and holds that the eosinophils have no special significance. Bubano[13] explains it as a local phagocytic process. Straubli,[1] Gruber,[14] and more recently Sternberg,[15] have regarded the eosinophils in the myocardium as having been drawn from the capillaries by a positive chemotaxis. We have no definite knowledge of the function of the eosinophils, and this renders more difficult a satisfactory explanation of eosinophilous myocarditis. We know that these cells take a prominent part in the reaction of the body to alien protein.[15] In helminthiasis, an eosinophilia arises owing to a substance introduced by the parasite into the host.[16] This substance actually attracts the eosinophil to the precise region in the intestinal wall that is injured by the worm.[17] In subacute appendicitis, the lymphatic structures of the appendix may be packed with eosinophils. Likewise, in gonorrheal salpingitis, the gonococcus causes a chemotaxis of sufficient intensity to attract large numbers of eosinophils to the tubal tissues.[18] In constitutional or familial eosinophilia, including hay-fever, gout, urticaria, mucous colitis, and asthma, a blood eosinophilia is often present, especially during convalescence.[18] Here, also, introduction of foreign protein into the body may be held responsible for the eosinophilia. Whether the eosinophils invade the tissue in these conditions is not known. In Hodgkin's disease, eosinophilic myelocytes and polymorphonuclear eosinophils are found in the lymph glands and in the blood as part of a terminal leukocytosis. These cells are morphologically slightly different from those found in eosinophilous myocarditis; but in Hodgkin's disease, the stimulus that leads to the production of eosinophilia may be so strong that disturbance of the bone marrow results with production of immature eosinophils.

In view of these conditions in which an eosinophilia occurs, and also the production of eosinophilia by the infection of alien protein, the most acceptable explanation of eosinophilous myocarditis seems to be that it results from a positive chemotaxis, some substance being present in the myocardium in response to which eosinophils migrate from the capillaries.

SUMMARY AND CONCLUSIONS

An eosinophilous myocarditis was found in seven of twenty-nine cases of diphtheria, but it was not present in many cases of death from various other acute infectious diseases.

The myocardial eosinophilia had no relation to the severity of the clinical symptoms or to the degree of myocarditis.

A moderate degree of cloudy swelling was found in the bundle of His and in the special impulse conducting system of the heart.

There is a possibility that the various types of arrhythmia in diphtheria are due to a compression of the fibers in the bundle of His as a result of moderate cloudy swelling or to the degenerative changes in this system.

The changes in the specific conducting system are not proportionate to the degenerative changes present in the myocardium.

In all probability, eosinophilic myocarditis is the result of a positive chemotaxis.

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9. Hume and Clegg: Quoted by Aviragnet and others.
10. Schlecht, H., and Schwenker, G.: Deutsch. Arch. f. klin. Med. **108**: 212, 1912.
11. Kulb: Die Erkrankungen der Herz muskel, Bergman, 1913, 341.
12. Herrick, W. W.: A Study of the Action of Atropin on the Eosinophil Cells of the Blood, Arch. Int. Med. **15**: 794 (May) 1914.
13. Bubano: Virchows Arch. f. path. Anat. **217**: 3, 1914.
14. Gruber, G. B.: München. med. Wchnschr. **61**: 647, 1914.
15. Sternberg: Beitr. z. path. Anat. u. z. allg. Path. **57**, No. 2, 1912.
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Public Health Nurse.—The public health nurse is to be considered one of the most simple, direct, and easily demonstrated means of health protection; and while the demand for public health nurses far exceeds the supply at the present time, it is hoped that the reaction will be such as will result in supplying the demand of public health workers.—*Am. J. Pub. Health* **9**:350, 1919.

METHEMOGLOBINEMIA DUE TO BROMO-SELTZER POISONING*

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REPORT OF CASE

History.—A white man, aged 36, was recently presented for diagnosis exhibiting marked cyanosis, associated with pallor, which gave him a peculiar leaden aspect. Respiration was not augmented to the degree ordinarily seen with a similar degree of cyanosis when due to deficient aeration of blood. At the age of 21, the patient had experienced "stomach trouble," manifested by pain after eating, which began at the left anterior costal margin, associated with abdominal distention and belching. The condition lasted for from one to two hours. At times vomiting occurred, which gave immediate relief. The symptoms were always accompanied by severe frontal and occipital headaches. The condition grew worse, and numerous kinds of medication were tried. The patient began taking bromoseltzer in 1911, about 5 ounces every three or four days. The headaches ceased, but the other symptoms persisted.

In 1912, the bromoseltzer was discontinued, but he began taking about one bottle of sal hepatica daily.

In 1913, he resumed the bromoseltzer, taking 5 ounces every three or four days. This he continued, gradually increasing the amount, until June, 1918, when three or four 5-ounce bottles were consumed daily. In October, 1918, he became weak, nervous, dizzy and restless.

From November, 1918, to April 20, 1919, the patient took from four to five 5-ounce bottles of bromoseltzer daily. April 23, 1919, he was admitted to the hospital. The chief complaints were nervousness, severe frontal headache, dizziness, and shortness of breath on exertion.

He was put to bed and given elimination treatment, sodium bromid and iron. The mucous membranes were very cyanotic; the skin was pale and dry, and there was considerable emaciation. The reflexes were exaggerated, but none that were pathologic were detected.

From April 27 to May 26, the patient was delirious, and physical restraint was necessary. From May 26, his mind began to clear gradually until June 10, when his mentality was normal, and he was up and around. At this time he stated that he felt better than he ever had in his life. There were still present slight cyanosis of the mucous membranes, skin pallor and general emaciation. The headache and dizziness had disappeared, though slight shortness of breath on exertion persisted.

He was discharged from the hospital, June 25, in good physical and mental condition and with no evidence of cyanosis.

Physical Examination.—This was negative except for a pale blue color of the skin, especially of the mucous membranes, lips and nail-beds. The pulse was regular but weak. While lying in bed, the patient experienced no respiratory distress.

Laboratory Findings.—The urine contained a faint trace of albumin, but there was no blood pigment. The blood count, April 24, was: red blood corpuscles, 4,400,000; white blood corpuscles, 8,100. The differential count was: polymorphonuclears, 70 per cent.; small lymphocytes, 15 per cent.; large lymphocytes, 15 per cent.; transitional, 0; eosinophils, 0.

Three samples of blood were obtained from the arm vein on the first, fifth and tenth days of May. The first sample of blood was of a dark hue with a brownish tinge, and on exposure to air, did not assume the bright scarlet hue characteristic of normal arterial blood. A portion was centrifuged, and clear serum was obtained. Spectroscopic examination of the serum failed to detect the spectrum of methemoglobin even in a thick layer. A portion of the whole blood, laked by adding water, showed, in addition to the oxyhemoglobin bands, a very pronounced absorption band in the red. On the addition of ammonium sulphid, the band in the red disappeared and the spectrum of reduced hemoglobin appeared. The position of the absorption band in the spectrum, and the reaction to ammonium sulphid, was that of methemoglobin.

The second sample, obtained five days later, was to all appearances the same as the first. The same dark hue was noted which on aeration did not readily become arterial in hue. A portion was centrifuged. The serum was blood tinged, owing to slight laking which had probably taken place after the blood was drawn from the vein. Spectroscopic examination of the serum and of the whole blood laked by adding water demonstrated the bands of oxyhemoglobin and a band in the red, which disappeared on the addition of ammonium sulphid, as in the first sample.

The third sample of blood, taken ten days after the first, still showed the dark color which, however, was less pronounced. On aeration, this sample was found to be noticeably brighter than the two previous samples, but it was still unlike normal arterial blood. The serum in this case was clear and no band of methemoglobin could be detected. Laked whole blood, however, still gave the spectrum of methemoglobin which, on the addition of ammonium sulphid, gave the characteristic reaction.

A fourth sample, obtained June 5, was to all appearances normal, rapidly becoming of arterial hue on aeration. Spectroscopically, only oxyhemoglobin could be detected.

As it is well known that many benzene derivatives, including phenacetin and acetanilid, when introduced into the body in sufficient amounts will convert hemoglobin into methemoglobin,[1] the presence of methemoglobin in this case is attributed to the acetanilid contained in the bromoseltzer.

The oxygen capacity was determined by the method of Van Slyke,[2] and the hemoglobin by the method of Palmer.[3] From the third sample the oxygen content[4] was also determined. The accompanying table shows the results together with the hemoglobin calculated from the oxygen capacity.

RESULTS OF TESTS FOR THE OXYGEN AND HEMOGLOBIN CAPACITY OF THE BLOOD

No.	Date	Oxygen Capacity, Volume per Cent.	Hemoglobin Calculated from Oxygen Capacity per Cent.	Hemoglobin, Palmer's Method, per Cent.	Oxygen Content Venous Blood, Volume per Cent.	Spectroscopic Examination for Methemoglobin
1	5/ 1/19	15.47	82.47	117.4	...	+++
2	5/ 5/19	16.06	85.81	116.5	...	++
3	5/10/19	17.06	92.06	115.6	7.2	++
4	6/ 5/19	19.60	102.55	104.0	...	Negative

In aerating the blood for the oxygen capacity determination, the persistence of the dark color on exposure to air was conspicuous, the blood remaining dark after from fifteen to twenty minutes of such aeration.

COMMENT

The difference between the hemoglobin as determined by the method of Palmer and as calculated from the oxygen capacity apparently was due to the methemoglobin, which does not give up oxygen to the vacuum but adds to the colorimetric determination. In the presence of methemoglobin, therefore, the hemoglobin as determined colorimetrically does not give the true picture of the oxygen carrying capacity of the blood.

It might be thought that the difference between the hemoglobin as determined colorimetrically and as calculated from the oxygen capacity would give the amount of methemoglobin present, but such is not the case. The amount of methemoglobin is more than indicated by the difference, as the methemoglobin is not converted quantitatively to carbon monoxid hemo-

* From the Department of Physiologic Chemistry, University of Pittsburgh School of Medicine.

1. Huebner, W.: Arch. f. exper. Path. u. Pharmakol. **72**: 241 (May) 1913.
2. Van Slyke, D. D.: J. Biol. Chem. **33**: 127 (Jan.) 1918.
3. Palmer, W. W.: J. Biol. Chem. **33**: 119 (Jan.) 1918.
4. Lundsgaard, Christen: J. Biol. Chem. **33**: 133 (Jan.) 1918.

globin, and its brownish tint does not match well with the standard.[5]

SUMMARY AND CONCLUSIONS

1. A man developed the bromoseltzer habit, which led eventually to the ingestion of extremely large quantities of the drug.

2. The outstanding features of the toxic effects were a persistent methemoglobinemia, associated with cyanosis and mental derangement.

3. The methemoglobinemia can probably be attributed to the acetanilid contained in the bromoseltzer.

4. The cyanosis can be explained on the basis of the change in the blood pigment. The altered pigment was shown by spectroscopic examination to be methemoglobin.

5. The oxygen capacity and oxygen content of venous blood would seem to indicate why the cyanosis was not associated with symptoms of air hunger except on exertion.

6. In the presence of methemoglobin, the determination of the hemoglobin colorimetrically does not give the true picture of the oxygen carrying power of blood, which, however, can be estimated by determining the oxygen capacity.

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ACTINOMYCOSIS TREATED WITH RADIUM

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In January, 1914, I demonstrated before the Medical Society of Christiania the first case of actinomycosis treated with radium.

REPORT OF CASES

Case 1.—A. O., a laboring man, aged 32, was removed Feb. 10, 1913, to the radium division from the surgical section where he had been under treatment since Nov. 30, 1912, for actinomycosis with swellings in the right cheek. December 7, the fistula on the outer side of the cheek had been incised and scooped out, a small quantity of pus together with a soft grayish granulation tissue being removed. A similar incision had been made on the inner side of the cheek in which a tamponade of xeroform gauze had been placed. The patient, since November 30, had gone through an internal treatment with potassium iodid. He then felt better until the beginning of February, 1913, when the swelling in the cheek grew so much that the eye slit finally disappeared. Feb. 10, 1913, he entered the radium division of the Rikshospital.

At entrance the right cheek was very swollen, especially under and outside the right eye: it was strongly injected, firmly infiltrated, and sensitive to touch. Close under the right eye was a fluctuating, more prominent area the central part of which was yellowish. The swelling reached farther, from the eyebrow to the hair and on the outer side to the ear, on the inner side to the nasolabial furrow. The mucous membrane of the cheek also was fixed, infiltrated and thickened. The eye slit was quite shut up. In front of the sternocleidomastoid muscle an edematous swelling was present.

February 11, the whole of the swollen cheek was subjected to radium treatment, and the patient had for three days (twenty-four hours in each place) 4 cg. of radium (tube preparation).

February 14, it was noted that the swelling had abated somewhat after his arrival.

April 3, the patient returned for renewed radium treatment. The swelling on the right cheek was now distinctly better, and the right eye was about half as wide as the left one; it is true that even now the cheek was red and infiltrated, but only over an area of about 4 square centimeters on the outside of and below the eye; a small abscess was seen in the center of the infiltration.

The patient was then subjected to another three days' treatment with about half as strong doses as the first time.

May 26, the patient came for further treatment; but as the cheek showed no more traces of the disease, he was released on the same day and has been well since.

Case 2.—A man, aged 17, came from the surgical polyclinic into the radium section, Feb. 25, 1914, on account of actinomycosis faciei and colli.

In the beginning of December, swallowing had become painful, and at the same time the left cheek and the neck under the left ear began to swell. The swelling increased slowly, and an abscess formed, from which there ran thin pus containing small granules (under the microscope found to contain actinomyces). Later on, several abscesses formed.

When he entered the radium section, a diffuse, firm infiltration reached across the left cheek up to the zygomatic arch, and to the ear. The infiltration covered part of the neck, the skin was very much injected, and in the infiltrated area several fistulous openings were to be seen.

In the mouth, in the mucous membrane above the left canine tooth, there was a projecting swelling the size of a bean, with a center of pus. Here could be felt glands, up to the size of a bean, hard and insensitive, on the neck alongside the front edge of the sternocleidomastoid muscle and in the supraclavicular fossa.

The radium treatment began, Feb. 25, 1914. On the outside tumor 21 cg. of radium (tube preparation) with lead filter, 1 mm., were placed for twenty-four hours, and a surface preparation of 2 by 1 cm. (0.5 mm. lead filter) in the mouth for five hours.

April 19, the radium treatment was repeated with half doses to meet a possible relapse. The patient was cured at the time, and no relapse had taken place at the last inspection, one year after radium treatment.

Case 3.—A laboring man, aged 44, suffering from actinomycosis colli, was transferred from the surgical section to the radium division, May 4, 1915.

The illness began with a small "lump" under the skin over the right lower jaw four months before his entrance to our section. This grew little by little and developed into an infiltration, as hard as wood, of the soft part of the neck. The swelling on the right side reached the mastoid process, downward to within a few centimeters above the sternoclavicular joint and across the middle of the throat to the angle of the left maxilla. The swelling was sensitive, the skin covering it was red, and there were indications of deep fluctuation, and actinomycetes were demonstrated in the pus of the abscess.

The radium treatment commenced, May 4. In all, 20 cg. of radium (tube preparation) were used, with a strong lead filter of 1 mm., for twenty-four hours.

A repeated treatment took place, June 9, with about a half dose as compared with the first treatment, and, July 30, the last radium treatment followed (4 cg. for twenty-four hours).

Case 4.—A man, aged 79, a mason by trade, was moved to the radium section, Jan. 15, 1914, from the surgical section, where he had been treated for actinomycosis.

According to the history, the illness had existed for five weeks. In the surgical section, an incision had been made on the outside of the neck whereby some pus had been evacuated: actinomycosis granules were found in the pus.

On his entrance to the radium section, the soft parts of the neck on the left side were infiltrated by a flat swelling, hard as wood, in front, measuring 10 by 10 cm., which reached to within a few centimeters across the middle line of the throat and behind to the back edge of the sternocleidomastoid

5. We have since devised a method for the determination of methemoglobin, combining the oxygen capacity and a colorimetric method, using a methemoglobin standard, a description of which we hope to publish shortly.

muscle, and from the collar bone to the lower jaw. The swelling was immovable on its base, the skin nodulated, infiltrated and bluish red. Pus trickled out through a fairly large incision.

It was a case of a serious, deep actinomyosis in the neck.

The patient was subjected to his first radium treatment, Jan. 15, 1915, and 10 cg. of radium (tube preparation) with lead filter of 1 mm. were used for twenty-four hours, also surface preparations.

As early as a few days after the radium treatment, a perceptible decrease of the disease was noted.

A repeated radium treatment was undertaken, March 2, with about the same doses The swelling was by this time evidently on the decrease, stretching in front to the middle line of the throat, above to within two finger breaths below the lower jaw, below to two finger breaths above the collar bone, and behind to the front edge of the sternocleidomastoid muscle. The infiltration had become considerably flatter.

One more after-treatment with surface radium preparations was arranged. The patient was now cured and has been well since.

CASE 5.—A man, aged 18, was brought into the radium section, Dec. 8, 1915, from the surgical section, where he had been under treatment for actinomycosis of the neck and face since the last of November.

The whole of the lower right side of the face was covered by a firm infiltration, hard as wood, stretching from the zygomatic arch across the whole of the right cheek and behind to the back edge of the sternocleidomastoid muscle and downward to within two cm. above the collar bone. The skin over the infiltrated part was slightly injected, and one part round the angle of the jaw was red and inflamed. Here, an area about as big as a florin, where a fluctuation might be traced, formed a lump. There was considerable trismus. The patient was able to open his mouth to a distance of 1 cm. between the upper and lower teeth. By puncture, a few cubic centimeters of pus were obtained, in which were found typical actinomycosis granules.

On the same day, an incision of the abscess was made and about a soupspoonful of pus was taken out. The radium treatment commenced, Dec. 9, 1915. In all 20 cg. of radium (tube preparation) were applied for twenty-four hours

Jan 22, 1916, a renewed radium treatment was applied with 20 cg. of radium, lasting twenty-four hours.

January 23, it was recorded that infiltration of the right cheek had considerably decreased; it now covered an area of 4 square centimeters below the ear and round the angle of the jaw Over the angle a small fistular opening was seen. The redness had decreased.

The radium treatment was repeated, March 1, 1916, with 14 cg. of radium for twenty-four hours.

CASE 6.—E. R., a farmer, aged 27, entered the surgical section, Feb. 2, 1916, because of actinomycosis colli. An extract from the history runs:

A month before pain in the throat also started difficulty in swallowing; he was hoarse and felt weak.

About a fortnight before, the neck began to swell on the right side just below the lower jaw. The swelling spread little by little over the right half of the face upward and downward to the jugulum. During the last days, the difficulty in swallowing had increased, and breathing had become difficult.

Feb. 2, 1916, the patient had difficulty in speaking. The temperature was 38.1 C. (100.6 F.). The tongue was strongly coated, and there was fetor ex ore. The right side of the neck was considerably swollen, the swelling covering the right half of the face upward to the lower edge of the orbit and to the right nasolabial furrow. Downward it reached 23 cm., over the sternum and a little beyond the middle neck line, backward to the upper back edge of the sternocleidomastoid muscle.

On the right side of the neck upward, the tissue felt firmly infiltrated. The skin was tight and bluish red. Farther down, below the lower jaw, fluctuation could be felt, and at the right of the middle line under the throat a lump the size of a large walnut was seen, which fluctuated strongly. The mouth and the fauces could not be examined, as the infiltration prevented the opening of the mouth.

Immediately after the patient's entrance into the surgical section, three incisions were undertaken, and pus was removed from a large abscess. In the offensive pus were found actinomyces. Radium treatment was started, Feb. 12, 1916. In all, 20 cg. of radium (tube preparation) with a lead filter of 2 mm. thickness were applied outside on the neck for twenty-four hours, and in the mouth 2 cg. of radium with a lead filter of 1 mm. thickness were applied for twenty-five hours.

The repeated treatment took place, March 28, with application of the same doses as the first time.

A slight thickening was still to be seen round the incision scars. The patient was permanently cured.

THE DIAGNOSIS OF CHRONIC CHOLECYSTITIS COMPLICATING CARDIAC LESIONS

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Although I do not wish to reflect invidiously on the judgment of other practitioners, still I think I am not making an extreme statement when I say that there is a tendency among some physicians to attribute to a discovered cardiac lesion most, if not all, of the symptoms of which the patient complains. This is illustrated by precordial pain. If opinion is sought by the patient because of pain in the region of the heart, and if the physician recognizes the existence of a valvular defect, for instance, the symptom is likely to be attributed to the heart and treatment instituted accordingly. If the pain is evoked or intensified by exercise, this is considered proof positive of the correctness of the conclusion, and the patient may be ordered to bed or at least told to keep quiet. Soreness of the pectoral muscles or tenderness of the intercostal nerves may not be recognized or may be ignored, and no careful attempt may be made to differentiate between myositis or simple neuralgia and angina pectoris, or to search for some focus of infection in the throat, mouth or digestive tract that may be responsible for the pain, irrespective of the cardiac lesion. That in some cases an indirect connection may exist between the pain and the state of the heart is admitted; but it is an error of judgment in most instances to conclude that the latter is the cause, and the former the effect.

What has been said of pain about the heart applies with equal, if not greater, force to certain symptoms pertaining to the digestive system. Acute attacks of indigestion, or especially what is termed "chronic stomach trouble," when complained of by a cardiopath, is very likely to be ascribed to the heart disease whether valvular or myocardial.

That persons with pronounced circulatory embarrassment are prone to disturbances of digestion is granted, in consequence probably of sluggish circulation, and therefore more or less pronounced venous stasis and altered gastric and intestinal secretions. Such digestive disorders generally show themselves as accumulations of gas causing eructation with or without fermentative acidity, and as annoying flatulence. But not infrequently, cardiac patients complain of attacks of pain, generally in the epigastrium, which they ascribe to their stomachs. Others may speak of "spells of biliousness" with soreness, especially on pressure either in the median line below the ensiform

cartilage or at either side, more frequently the right. If on examination the physician detects enlargement and tenderness of the liver, he is very likely to conclude that the symptoms are due to passive hepatic congestion, and the latter to defective circulation in consequence of the heart disease.

CHOLECYSTITIS AND CARDIAC DISEASE

In 1909, I[1] pointed out the injurious influence of gallbladder disease on the heart, and cases were cited of serious cardiac incompetence even to the production of dangerous dilatation, a condition corrected wholly or in part by drainage of the gallbladder. Since that time I have never failed to pay special attention to the possibility of cholecystitis in every person with heart disease of whatever nature who complains of indigestion or subdiaphragmatic pain, and frequently I have detected evidence of gallbladder disease.

The history is rarely diagnostic, but is often very suggestive. From an etiologic standpoint, typhoid fever earlier in life may furnish a clue; but even when that is wanting, the history of inflammatory rheumatism or of some other streptococcus infection may be significant, since Rosenow's investigations have proved the presence of streptococci in the mucous membrane of the infected gallbladder more often than of the typhoid bacillus. Then, if the patient lays stress on symptoms referable to the digestive tract rather than on respiratory difficulty, or if attacks of palpitation occur at night or without such provocation as exercise or excitement, and especially if such attacks are accompanied by epigastric distress, attention should be addressed to the abdominal organs, that is, the gallbladder and appendix. And here it may be stated that the appendix is not seldom the offending structure, a fact to be considered in some future paper. Duodenal and gastric ulcers also must be borne in mind, but their symptomatology is so unlike that of cholecystitis that the physician need rarely be confused. Their differentiation need not be discussed here.

Gallstone colic when severe is not apt to be overlooked and is likely to be mentioned by the patient in reciting his history. It is chronic cholecystitis with or without the formation of calculi sufficient to excite distinct colic that is the real subject of this discussion. Therefore, in studying the anamnesis and symptomatology, the physician should not disregard data, no matter how insignificant they may seem to be.

It should be kept in mind, however, that pain of a sort different from intense hepatic colic is a frequent symptom, and also that its cause may be different. The pain now referred to is rather more a feeling of soreness or distress than an agonizing colic, and may be due to distention of the inflamed viscus instead of its attempt to expel a calculus, or to the passage of a stone along the cystic or the common duct. When due to distention of the gallbladder or to congestion of the liver, the distress is likely to be more continuous and not so spasmodic as when caused by calculi. The location of the pain may be various and referred to the epigastrium or to the precordial region, or it may radiate upward over the anterior or posterior aspect of the chest on the right side.

According to my observation, nausea and vomiting need not be pronounced features any more than is jaundice. When these do occur they are very apt to be attributed by the sufferer to acute indigestion especially if succeeded by cessation or decided diminution of pain. These are the symptoms so commonly regarded and mentioned as "attacks of biliousness."

That the differential diagnosis of chronic cholecystitis is often a matter of great difficulty is readily admitted. It requires not only a discriminating study of the history, possible etiology and symptomatology, but also a careful examination of the abdominal contents. By the last is meant a painstaking and precise palpation of the liver. In most instances of cholecystitis, this organ is plainly palpable, the degree of its enlargement depending chiefly on the acuteness of the gallbladder infection and the frequency, as well as the intensity of the symptoms produced.

The liver is not ordinarily palpable, or at most only its thin, smooth, regular lower edge can be felt during forced inspiration; therefore distinct enlargement of this organ is significant of some unusual influence brought to bear on it. In cases of cardiac disease, enlargement of the liver is the result of passive congestion and is so frequently observed that, when due to chronic cholecystitis in a cardiopath, one may very naturally attribute its increase in size and tenderness to stasis in consequence of impeded circulation. It is this very circumstance that renders the diagnosis of gallbladder infection difficult as a complication of cardiac lesions.

The following points are of great aid in arriving at the diagnosis: in passive hepatic congestion from heart disease, the organ preserves its natural and characteristic outline unless this is prevented by adhesions or by changes produced by cirrhosis, the chronic indurative cirrhosis of long-standing portal stasis. When not cirrhotic, but merely swollen by congestion, the left lobe is palpable and tender as well as the right, and one can detect the notch separating the two lobes. This is a point of great importance in cases of cardiac, particularly valvular disease. Furthermore, when secondary passive congestion of the liver exists one is very likely to find evidences of venous stasis in other organs and tissues. Consequently, the physician should search for these before concluding that the liver changes are the result of passive congestion merely. These being absent and the symptoms being referable to the abdomen rather than to respiratory embarrassment, suspicion should be attached at once to the liver, not to the heart.

RIEDEL'S LOBE

When cholecystitis is responsible for enlargement of the liver, it causes a characteristic alteration in the form of the right lobe first described by Riedel[2] in 1892, and hence known as Riedel's lobe. As a rule, the more acute the gallbladder infection, the more pronounced is this change in the outline of the liver; and yet this may occasionally be very pronounced in cases of chronic cholecystitis. This alteration consists in a convex enlargement of the right hepatic lobe downward, so that the edge of the organ curves downward toward the right for a variable distance and then upward to or shortly below the margin of the ribs. In some cases, this convex bulging may be small and obscured by the right rectus muscle, while in others, Riedel's lobe may reach from the median line nearly or quite to the extreme limit of the liver at the right. It may be noted also by careful palpation that the portion

1. Babcock, R. H.: Chronic Cholecystitis as a Cause of Myocardial Incompetence, J. A. M. A. 52: 1904 (June 12) 1909.

2. Riedel, B. M. C. L.: Erfahrungen über die Gallensteinkrankheit mit und ohne Icterus, Ed. 8, Berlin, W. Gronau, 1892, p. 11.

of the viscus lying to the left of the median line is not at all, or only indistinctly, palpable.

In pronounced instances, there may be an appreciable bulging of the part of the liver overlying the gallbladder, so that in well-marked cases it gives the impression of a rotund mass like an orange beneath the liver. If the liver or the gallbladder is sensitive to pressure, the right rectus muscle is apt to stiffen in distinct contrast to the corresponding muscle on the left side. If Riedel's lobe is small, it may be obscured by the rigid muscle, and yet by careful palpation the liver may usually be detected at either side of the rectus, and with the characteristic convex shape described.

In many cases on deep inspiration, the hand can detect the softer and exquisitely tender gallbladder itself extending slightly below the lower edge of Riedel's lobe, while in others the hand must be thrust sharply upward underneath the edge of the liver in order to come in contact with the gallbladder and elicit evidence of pain. This procedure causes the patient to cry out and shrink from the hand, and is followed by unmistakable rigidity of the right rectus muscle.

Palpation of the liver in these cases is a fine art. Not only should the knees be elevated so as to relax the abdominal walls, but the flank should be raised either by the examiner's left hand or by a firm cushion; and the physician should avoid too firm and rough palpation since by so doing he is likely to frustrate his own object. I have frequently been able to feel the lower edge and the shape of Riedel's lobe by merely resting my flat hand lightly on the abdomen and allowing the patient to breathe regularly and with moderate force. By so doing, pain is avoided, the abdominal walls remain relaxed, and the lower hepatic border can be perceived to glide back and forth beneath the hand. If this procedure is performed at each side of the median line alternately, the state of the two rectus muscles, as well as the outline of the two hepatic lobes may be compared.

Another sign of gallbladder disease of corroborative value in some cases is the so-called Ewald's area of cutaneous hyperesthesia on the right lower back. When this is present, simultaneous stroking of the two sides behind, from above downward, just internal to the posterior edge of the scapula, will elicit more or less sensitiveness of the skin at the right, over the course of the tenth and eleventh intercostal nerves. This sign has seldom been absent in cases of well-marked cholecystitis as shown by the evidence obtained by palpation of the liver.

The degree of systemic disturbance, as shown by the temperature and leukocytosis, depends on the intensity of the gallbladder infection. If the cholecystitis is chronic, revealing its presence chiefly by digestive disorder and only moderate pain, the body temperature may be but slightly, if at all, raised, and may not even attract the patient's attention, while during the intervals between attacks of acute distress the temperature is likely to be quite normal. Indeed, it may be said that the freedom from febrile or other systemic disturbance furnishes one reason why these chronic cases are apt to escape detection.

The leukocyte count in like manner is subject to slight deviation from normal. In strictly chronic cases without marked symptoms, the leukocytes are not likely to show an increase of over eight or nine or possibly ten thousand with, of course, no pronounced preponderance of the polymorphonuclear elements. One should be careful not to regard slight increase in temperature and white count in a given case of valvular disease as indicating an exacerbation of a chronic endocarditis. Except in acute instances of cholecystitis, more information is to be obtained by history, subjective symptoms, and painstaking manual examination than by study of temperature and leukocytes or even roentgenologic examination unless, of course, the roentgen ray is so fortunate as to disclose the presence of stones.

REPORT OF CASES

CASE 1.—Mrs. J. H., aged 54, the mother of nine children, on examination in November, 1917, was found to be corpulent and to display dyspnea on exertion, this together with some edema of the left leg, bleeding hemorrhoids, and cough constituting the symptoms for which she sought relief. There was a history of inflammatory rheumatism, typhoid fever, pneumonia and an attack of heart collapse a year and a half prior to my examination.

The pulse was accelerated and irregular, of the type due to auricular fibrillation. The systolic pressure was 140 mm. as nearly as could be determined, while the diastolic stood at 90 mm. The apex beat was 4½ inches to the left of the median line, and the transverse dulness seemed to be fully 6 inches. The mitral first tone was indistinct because of a soft systolic murmur, and the pulmonic second tone was accented. The liver was palpable and tender, but not uniformly so, as the left lobe was rather larger than was the portion to the right of the median line. The lungs were negative, and the single specimen of urine examined in the office was also negative.

The diagnosis was myocardial incompetence with mitral insufficiency, hepatic congestion and obesity. Digitalis, cathartics, rest and light diet were prescribed. During the succeeding year, this patient was seen only two or three times. At these times she showed very little improvement despite continuance of treatment.

In April, 1919, she suffered an acute stomach disturbance, and was seen by another physician who diagnosed acute cholecystitis. As the symptoms subsided after a few days of treatment, I did not see the patient until July, 1919, when she appeared because of aggravation of the original complaint. The heart was as before, except perhaps rather more arrhythmic and rapid. On going over the liver, we were at once struck by the distinctness of Riedel's lobe, and by the circumstance that directly beneath and below its inferior margin there could be felt a soft, very tender mass that was evidently the gallbladder. During 1918, suspicion had been aroused regarding the existence of a chronic cholecystitis, though the characteristic alteration in the outline of the liver did not become distinct until after the acute attack in April, 1919.

The advice to have the gallbladder drained was heeded, and when the gallbladder was opened, hundreds of small stones were discharged. A drainage tube was inserted, and the viscus was allowed to drain for a number of weeks. The patient's condition is now greatly improved. Her heart is still irregular, but the systolic pressure has increased twenty points which, taken in connection with the lessened dyspnea, the loss of stomach symptoms and her ability to attend to household duties daily, is taken to signify increased strength of the myocardium.

Here was a case thought to be one of heart disease alone, but which was complicated by a gallbladder infection which, as the operation has proved, was in reality the factor most responsible for the symptoms for which relief was sought.

CASE 2.—Miss A. B., aged 34, first seen in December, 1918, was tall and thin, having lost 45 pounds during the previous six months. There was a history of inflammatory rheumatism, several "grip attacks," and in the preceding January what was thought to be pleurisy on the right side, with fever, nausea and vomiting. She complained of great shortness of

breath, cough and stomach trouble. Physical examination disclosed a feeble, irregular pulse of the fibrillating type, a very low pulse pressure, the systolic being 110 mm. as nearly as could be determined because of the great arrhythmia, and the diastolic about 100 mm., pulsating jugulars and a markedly dilated heart with the characteristic rumbling murmur of mitral stenosis, while the tender lower border of the liver extended to the level of the umbilicus. This organ was engorged generally, and yet its right lobe suggested, though not distinctly, a Riedel lobe. The lungs also showed congestion, and the urine contained albumin.

The condition was regarded so serious that she was ordered to bed, and of course given other suitable treatment. Constipation was a marked and very obstinate symptom. The condition did not improve much, and in February, 1919, she rather suddenly developed unmistakable signs and symptoms of acute cholecystitis, jaundice and high temperature, so that an operation became urgently indicated. This was successfully performed under local anesthesia, and two stones were removed from the cystic duct. Bile did not flow for ten days, but then came freely, and improvement followed promptly. At present this patient is so well that she is at work daily. The gallbladder must be kept draining, for as soon as the opening closes, the heart begins to grow more irregular and rapid, and the patient soon thereafter displays perceptible icterus. From a purely surgical standpoint, cholecystectomy is indicated; but it is doubtful whether her heart would enable her to survive the operation. We are content, therefore, to let well enough alone.

This case illustrates the difficulty of recognizing chronic cholecystitis complicating a decompensated cardiac lesion. The acute attack in February, 1919, was so typical in the spasmodic pain running up into the right back and shoulder, the nausea, vomiting, and twenty-four hours later the intense icterus, that one does not understand how it could be overlooked. Yet the patient herself recognized its features as identical with the attack in January, 1918, which was pronounced pleurisy and was followed by the cardiac incompetence for which advice was sought in the following December. It is my opinion that had I given more attention to the history of the supposed pleurisy, and examined the greatly engorged liver more carefully, I might have recognized the existence of the gallbladder infection before it made itself so obvious by its acute exacerbation. It strengthens my belief that in every case of cardiac disease with a history or symptoms of abdominal disturbance, minute attention should be paid to the gallbladder and appendix, the latter in many cases being the chief offender, as I hope to show in some future communication.

Case 3.—Mr. S. B., seen first in 1916, reappeared in March, 1919, with the statement that he had been in bed for nine weeks because of broken compensation. He was cyanotic, and was suffering much from dyspnea and cough. Physical examination disclosed a hypertrophied heart in consequence of aortic regurgitation, numerous mucous râles at the base of the right lung behind, and a palpable tender liver. The leukocytes numbered 10,000, and the urine contained albumin.

The young man was sent to a hospital and placed under suitable treatment, with the result that at the end of a week or ten days the lungs had become free of râles, and he no longer complained of dyspnea. The pulse also had greatly improved in rate and rhythm. But he now complained a good deal of trouble with his stomach. Catharsis and the rest in bed had reduced much of the hepatic congestion, so that on palpation one could detect very easily a Riedel lobe, this portion of the liver being very sensitive to pressure. Underneath could be detected what seemed to be the softer and even more tender gallbladder. As all symptoms referable to the respiratory system had subsided, and as the circulation was satisfactory, and as the digestive disturbance interfered with proper rest, he was informed of the cholecystitis and advised to have the gallbladder opened and drained under a local anesthetic. To this, however, he would not consent, and he left the hospital abruptly for his home. No report from him has been received since his departure.

This case, like the preceding, illustrates the difficulty of recognizing the existence of chronic cholecystitis in a person suffering from the distressing symptoms of broken compensation of a coincident cardiac lesion. But it also emphasizes how serious may be such a combination in its effect on convalescence, that is, restoration of cardiac efficiency, and how important is a close study of the hepatic condition. It is so natural to regard the obvious circulatory embarrassment as responsible for the phenomena that unless each organ is scrutinized daily, we may overlook complications capable of turning the scales against recovery.

30 North Michigan Avenue.

ALLEVIATION OF DISTRESSING DIGESTIVE SYMPTOMS IN "CARDIO-RENAL DISEASE"

SOME SUGGESTIONS

GEORGE M. NILES, Ph.G., M.D.

ATLANTA, GA.

All practitioners of medicine, particularly those specializing in gastro-enterology, have patients with so-called "cardiorenal insufficiency" who complain of indigestion, of distressing flatulence, of sensations of epigastric fulness after eating, and of a general feeling of digestive discomfort. These patients may present valvular lesions in various stages of compensation: there may be arrhythmia or myocardial inefficiency or tumultuous heart action. The urine may be loaded with albumin, may show granular or hyaline casts or both, or at times it may be fairly normal. The questions of actual cardiac and renal pathology will not be discussed in this study, but rather the methods of steadying the heart's action, of aiding compensation, of allowing more physical space to the thoracic and abdominal organs, so that they may be less handicapped in performing their functions, and of lightening the work of the kidneys.

As a cardiac "steadier" plus a diuretic, I have much confidence in the *infusion* of digitalis—more, perhaps, than in any other preparation of this drug. However, the infusion must be fresh and must be made from fresh and dependable digitalis *leaves*, otherwise the results will be disappointing. It is my custom to give one-half ounce, four times the first day, especially if the pulse is accelerated. After that I have found 2-teaspoonful doses, four times daily, a sufficiency. It is well to omit it altogether every fifth day, and if the pulse becomes rather slow, to omit it every fourth, or even every third day. This minimizes the danger of a cumulative effect. Unless the bowels are loose, which is seldom the case, I employ, with good effect, this prescription:

℞ Magnesii sulphatis
Potassii bitartratis (C. P.) ..... āā ʒ iii
Triturate finely.
M. Sig.: Two teaspoonfuls in one-half glass of water on arising.

This prescription should produce two or three free watery stools, but the dose may be varied to obtain that result. In some instances, when the watery move-

ments seem to cause debility, this prescription may be given on alternate mornings, or even three days apart.

For the distressing accumulation of gas in the stomach, which so embarrasses the heart's action, this prescription has proved most helpful:

℞ Spiritus anisi ..... ʒ ii
Zinci phenolsulphonatis ..... gr xv
Magmae magnesiae ..... ʒ iiss
Aquae ..... q. s. ad. ʒ iv
M. Sig.: One teaspoonful every fifteen to thirty minutes as needed for gas.

This can be repeated almost ad libitum. It can produce no bad effect, unless the magnesia acts as a hydragogue cathartic, and generally it promotes the free expulsion of the disquieting gas, of which the patient complains so bitterly. In many of these uncompensated cases there is frequent dyspnea, coming on after slight exertion or without apparent cause, or deepening in intensity during the hours of night.

The following combination, while it unfortunately possesses an odor both foul and fierce, has to many sufferers under my observation afforded a most grateful surcease for this distress:

℞ Spiritus ammonii aromatici
Elixir ammonii valerianatis ..... āā ʒ iss
M. Sig.: One teaspoonful in water every fifteen minutes to one hour as needed for difficult breathing.

This, like the previous prescriptions, may be repeated quite a number of times.

Dietetic restrictions and regulations are most important, as they tend to diminish intestinal flatulence, to encourage intestinal peristalsis, to lighten the eliminative burden of the kidneys, and to promote general nutrition.

In the suggestive dietary herein offered, it will be noted that sweets and fats are avoided, so far as possible, and that vegetables containing only 5 and 10 per cent. of carbohydrates are allowed, while the starchy foods are for the most part prohibited. Fresh lean meat may be eaten freely, but must be broiled, baked or roasted. The string beans, squash, onions, turnips, etc., may be cooked, but the green vegetables, usually eaten raw, may be cut up into a combination salad and flavored with lemon juice instead of the ordinary condiments. A limited amount of fresh buttermilk is admissible, and a small amount of cereal for breakfast, if the patient insists on it, as sometimes is the case. When cereals are eaten, a very scant amount of sugar may be permitted.

SUGGESTIVE DIET LIST

FOODS ALLOWED

Lettuce; cucumbers; spinach; asparagus; sauerkraut; beet greens; greens (turnip, mustard or collard); celery; tomatoes; brussels sprouts; okra; cauliflower; egg plant; cabbage; radishes; leeks; onions; string beans; pumpkin; turnip; squash; beets; carrots; ripe olives; grapefruit; lemons; oranges; unsweetened pickles; clams, oysters, liver, roe; lean fresh meat of any kind, as beef, mutton, pork, chicken, fish or game; coffee or tea as sparingly as possible, and fluids, only enough to quench actual thirst.

FOODS TO AVOID

Sweets of all kinds; fats, as fat meat, butter and cream; sweet milk; eggs, and starchy foods, as breads, rice, grits, potatoes, dried beans or pears, and macaroni.

This diet will seem quite a revolutionary change to many patients, and some will for a while complain at the prohibition of breads and sweets especially. In a short time, however, in a majority of cases, the intestinal flatus will markedly diminish, the dyspnea will lighten, the heart will become more steady and efficient in its action, and the albuminous content in the urine will lessen or entirely disappear.

This dietary does not promote a gain in weight. On the contrary, there is generally some loss; but this is not prejudicial to the invalid's welfare. As general improvement progresses, certain variations or modifications in the daily regimen may be allowed; but any inclination to increased dyspnea or inefficient heart action should indicate the necessity for a prompt return to the strict diet and regular medication.

There will, of course, be found some persons who lack the mental stability required for the successful advancement of this method; then, too, there will be found both hearts and kidneys seemingly beyond the power of compensation or recuperation.

Nevertheless, in a liberal proportion of these melancholy and long-suffering "cardiorenal cases," the brief, but practical suggestions herein offered will be found decidedly helpful.

922 Candler Building.

CUTANEOUS REACTION TO QUININ IN QUININ IDIOSYNCRASY*

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Some individuals are susceptible to the action of certain foreign substances. The urticarial rashes brought on by strawberries, the eczematoid dermatoses due to various proteins or food products, the asthma caused by white of egg, the hay-fever or asthma caused by pollens of plants or by inhalations of animal emanations or derivatives, the skin reaction to tuberculin, and the various symptoms following the use of certain drugs are specific examples of such idiosyncrasies. Symptoms commonly observed in hypersensitive individuals are: (1) urticarial or eczematoid rashes; (2) gastro-intestinal disturbances; (3) those characterized as asthma, or (4) those indicating exaggerated pharmacologic action of the antigenic drug.

Among the drugs to which man manifests this idiosyncrasy is quinin. This fact has long been known.

An attempt to develop a specific skin reaction to quinin was successfully made by Boerner.[1] By applying quinin bisulphate to a skin scarification made on himself and a colleague—both of them susceptible to quinin—he was able to obtain a definite and well marked local reaction in each case. Similar skin tests in nonsusceptible individuals gave no reactions whatever. Boerner[1] concluded, therefore, that this reaction was specific and was most pronounced when using a 10 per cent. solution of quinin bisulphate.

O'Malley and Richey[2] tried out this skin test in two cases of quinin idiosyncrasy under their observation. They used 10 per cent. quinin bisulphate and obtained definite reactions, thus confirming Boerner's observation. They also obtained an equally well marked local reaction with a 5 per cent. solution of quinin dihydrochlorid. With cinchonin or cinchonidin sulphate, and with various other drugs tested, they could get no reactions whatever. In twelve nonsusceptible persons, no reactions could be obtained with quinin sulphate. These observers concluded, therefore, that this skin reaction is a good index of hypersensitization to quinin.

In the case herewith presented, which recently came under my observation, this skin reaction was tested out with the idea of determining its value.

* Read before the Twelfth District (Indiana) Medical Society, Fort Wayne, Ind., Nov. 12, 1919.

1. Boerner, Fred, Jr.: A Skin Reaction to Quinin, J. A. M. A. 68: 907 (March 24) 1917.

2. O'Malley, J. J., and Richey, D. G.: Cutaneous Reaction and Desensitization in Quinin Idiosyncrasy, Arch. Int. Med. 24: 378 (Oct.) 1919.

REPORT OF CASE

Mrs. T. S., aged 54, entered St. Joseph's Hospital for a rest cure. On the day of admission she was given 1 dram of the elixir of iron, quinin, and strychnin (N. F.), which contains one fourth grain of quinin. Immediately after taking this dose, she felt a peculiar "drawing up" sensation over the middle of the chest, which lasted several minutes. She promptly asked whether there was any quinin in the medicine she had just taken; and when informed that there was, she said that she had never been able to take that drug.

About an hour later a weltlike exanthem appeared over the entire body except the face. With the exanthem, there was intense itching. The lesions and itching were worse over the back, under the arms, and on the lower extremities. When seen several hours later, the skin manifestation presented the appearance of a generalized urticaria. It began to fade in from sixteen to eighteen hours, and disappeared completely in about thirty-six hours.

The patient said that about twenty-seven years before she had had an acute attack of grip, for which she was given quinin. After several doses—the size of which she did not know—a rash and severe itching came on all over her body, and lasted from four to five days. On at least two other occasions she had been given quinin, and each time the same symptoms occurred within a few hours. So far as she knows she is the only member of her family who manifests any symptoms after taking this drug.

REACTION TEST

The opportunity thus presented itself to test out the cutaneous reaction already described. Accordingly, October 19, and again, November 5, the skin of the forearm was scarified in two places about 3 inches apart. Over the proximal abrasion 10 per cent. quinin bisulphate in aqueous solution was applied. The distal scarification served as a control. Within a few minutes the patient began to feel an itching sensation around the scratch into which the quinin had been rubbed. A few minutes later an edematous papule began to appear around this scarification. It reached its maximum size, about 0.75 cm. in diameter, in about one-half hour. Surrounding this area of edema was a bright reddish patch of erythema measuring about 3.5 cm. in diameter. The reaction began to subside after the first half hour, and at the end of a few hours had completely disappeared. Around the distal or control scarification, nothing worthy of note occurred other than the usual normal reaction following traumatism of that kind.

The cutaneous reaction described was striking and unmistakable. It was tried out twice in this case, and the reaction was exactly identical. Evidently the cutaneous reaction to quinin is not only very definite but also rather characteristic, and can really be regarded as a specific biologic phenomenon.

SUMMARY

1. The case of idiosyncrasy to quinin recorded herewith further confirms the skin reaction to quinin, worked out by Boerner[1] and confirmed by O'Malley and Richey.[2]

2. This reaction is observed only in individuals who are hypersensitive to this drug, and can be obtained by using only quinin salts as the antigen.

3. It seems to be a specific reaction, analogous to the other cutaneous reactions already known.

4. As a method for testing out hypersensitization to quinin, this skin test seems to be very reliable and ought to be of very great value.

409 West Main Street.

THE MAXIMUM NONFATAL OPENING OF THE CHEST WALL

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In a previous article, by the present writer in conjunction with R. D. Bell,[1] evidence was presented to show that in the normal thorax the pressure relationships are always practically equal in both pleural cavities and that therefore the prevalent conceptions of collapse of one lung and maintenance of respiration with the other in the condition of open pneumothorax are incorrect. In the same article also, it was shown that a bilateral open pneumothorax in a normal chest is practically no more dangerous to life than a unilateral opening unless the combined areas of the openings on both sides are greater than the area of the single opening on one side. Both theoretically and experimentally effects of practically the same severity result in the case of one or more openings into one pleural cavity as follow the creation of a double pneumothorax, provided that in each case the combined areas of the various openings are equal. Moreover, it was shown that the maximum opening in the chest wall compatible with life in the normal adult (that is, without pleural adhesions or induration of the mediastinum) could be approximated by means of the mathematical expression:

$$X = \frac{V - \frac{R_1}{R_2}T}{\frac{R_1}{R_2}T - eC}$$

in which V is the vital capacity
R_1 is the rate of respiration before the opening is made
R_2 is the rate of respiration after the opening is made
T is the tidal air (approximately 500 c.c.)
e is a factor less than 1 (assumed to be 0.8).
C is the area of the glottis (about 2.25 sq. cm.)

In the substitution of numerical values, 3,700 was used to represent the vital capacity.[2] This was the commonly accepted average vital capacity, and on the basis of it a value for X was obtained of 51.5 sq. cm. (8.1 square inches). In other words, the computation was made that an opening of 51.5 sq. cm. in the chest wall was the maximum for which compensation could be made. At that time we were not acquainted with the work of Peabody and Wentworth[3] on the vital capacity. In their study it was found that in general the vital capacity of men is greater than that of women, and that an approximate relationship exists between the height of the individual and his vital capacity. In men, for example, the average normal vital capacity is 4,633 c.c.; but in men 6 feet or more in height, the normal vital capacity is 5,100 c.c., and in one man it was found to have the very high value of 7,180 c.c. The accompanying tables are quoted from their article.

It is at once obvious that whenever the value of V in our mathematical expression changes, the value of X will also change in the same direction, that is, if V becomes greater, the value of X will also be increased, and vice versa. If in substituting numerical values in our equation we insert 4,800 for V (the normal vital capacity of men with a height of from 5 feet 8½

1. Graham, E. A., and Bell, R. D.: Open Pneumothorax: Its Relation to the Treatment of Empyema, Am. J. M. Sc. 156:839 (Dec.) 1918.
2. Howell: Textbook of Physiology, Philadelphia, 1911, p. 646.
3. Peabody, F. W., and Wentworth, J. A.: Clinical Studies of the Respiration, IV, The Vital Capacity of the Lungs and Its Relation to Dyspnea, Arch. Int. Med. 20:443 (Sept.) 1917.

inches to 6 feet), instead of 3,700 we obtain a distinctly larger value for X. If we assume as before that R_1 (the rate of respiration before making the opening) during complete rest is 15 per minute and the maximum rate, R_2, for the greatest possible depth of respiration is 60 per minute, then:

$$X = \frac{4800 - 125}{125} aC = 37.4 \times 1.8, \text{ or}$$

$X = 67.32$ sq. cm., or 10.4 sq. inches

Criticism has been made of the incorrectness of our mathematical expression on the ground that the value obtained for the maximum opening compatible with life, which was published in our previous article, was too small when compared with what was sometimes found clinically to be possible in connection with both war and operative wounds of the chest. But it should be remembered that the value of 51.5 sq. cm., which was previously given, represented merely an average value based on what was commonly considered as the average value of the vital capacity. As found in the

TABLE 1.—VITAL CAPACITY OF THE LUNGS IN NORMAL MALES

Group	No. Studied	Height in Feet and Inches	Normal Vital Capacity C.c.	No. Within 10% of Normal	Highest Vital Capacity C.c.	Lowest Vital Capacity C.c.	Highest Percentage	Lowest Percentage	No. Below 90% of Normal
I	14	6′+	5,100	9	7,180	5,030	141	99	0
II	44	5′8½″ to 6′	4,800	41	5,800	4,300	121	90	0
III	30	5′3″ to 5′8½″	4,000	21	5,080	3,450	127	86	1

TABLE 2.—VITAL CAPACITY OF THE LUNGS IN NORMAL FEMALES

Group	No. Studied	Height in Feet and Inches	Normal Vital Capacity C.c.	No. Within 10% of Normal	Highest Vital Capacity C.c.	Lowest Vital Capacity C.c.	Highest Percentage	Lowest Percentage	No. Below 90% of Normal
I	10	Over 5′6″	3,275	5	4,075	2,800	124	86	2
II	12	5′2″ to 5′6″	3,050	9	3,425	2,600	112	86	2
III	21	5′1″ or less	2,825	16	3,320	2,500	135	89	1

usual type of war surgery, this value was probably somewhat too small because of the fact that, as Peabody and Wentworth have shown, the average vital capacity of men is greater than that of women and is therefore greater than the general average vital capacity. Obviously also in the exceptionally large man of athletic build, as for example in the case of the man Peabody and Wentworth mention, who had a vital capacity of 7,180 c.c., a relatively enormous opening in the chest wall can be compensated for. In such a case, for instance, the value of X in our equation would be 101.3 sq. cm., or 15.6 square inches. It should be remembered also, as stated in our previous article, that what are often apparently very large operative openings in the thoracic wall are actually smaller than they seem to be because of the presence in the incision of a lung which has been delivered out, gauze sponges, instruments, fingers of the operator, etc., all of which tend by their plugging to reduce the area of the opening and the amount of air which is sucked in at inspiration. On the other hand, it should be borne in mind that the value of X represents the approximate maximum opening compatible with life only so long as the respiratory muscles can maintain a maximum respiratory movement, and in addition, that it is only an approximation because of the variability in different individuals of some of the other factors, as for example, C.

The validity of the statement in our former article that the value of X would be diminished by the presence of toxemia, infection, or any other cause which increases the level of metabolism, as well as by any condition which reduces the available breathing space of the lungs, has been confirmed at least in numerous observations on acute empyema by other observers as well as ourselves. Also, Peabody and Wentworth have found that in nine patients with pleural effusions, the vital capacity varied between 74 and 42 per cent. of the normal. One patient with a massive pleural effusion had a vital capacity on two successive days of 48 and 49 per cent. Immediately after the aspiration of 2,200 c.c., his vital capacity was only 46 per cent. On the two following days it had risen to 69 and 68, and three weeks later it was 74 per cent. This observation is of particular interest in showing that the mere withdrawal of a pleural effusion is not sufficient to increase the vital capacity immediately, and it is therefore in direct opposition to a common belief that in cases of acute empyema, the danger of an open pneumothorax created for drainage can be disregarded because the withdrawal of the effusion will in itself immediately relieve the patient sufficiently to make an open pneumothorax safe.

Obviously, this mathematical expression does not hold good for conditions in which the mediastinum has become more or less immobilized by induration or by adhesions.

Clinical Notes, Suggestions, and New Instruments

IDIOSYNCRASY TO ALCOHOL

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In prescribing tinctures and elixirs, one is too prone to forget that they contain alcohol and to think only of the drug which forms the main constituent of the medicine.

I have been able to find no reference in textbooks of materia medica and therapeutics to susceptibility of patients to alcohol given in minute doses. The case reported below is unique, therefore, because of the patient's marked idiosyncrasy to alcohol even in very small quantities.

REPORT OF CASE

Mrs. C., aged 28, Chinese, whose previous history was unimportant, when seen, Nov. 21, 1918, reported that six months previously, after giving birth to a child, she developed a cough with hemoptysis. Physical examination disclosed advanced pulmonary tuberculosis. The disease progressed steadily until the patient was last seen in June, 1919. At this time both lungs were extensively involved, and a fatal termination of the disease appeared to be near at hand.

On my first visit I prescribed:

	Gm. or C.c.
℞ Elixir terpini hydratis et diacetylmorphinae (N. F.)	90
Aquae destillatae ad	180

Sig.: 15 c.c. every four hours as required for cough.

Estimating the amount of alcohol by assuming that 95 per cent. alcohol was used in preparing the elixir, we find that in 15 c.c. of the mixture there would be about 2.85 c.c. of absolute alcohol in solution. The patient's husband informed me when I next saw him that each time after taking this medicine his wife's face became flushed and she showed mild symptoms of alcoholic intoxication. The beneficial effect of the medicine in controlling the cough led me to continue its administration from time to time, but it was always attended by mild symptoms of intoxication.

A number of other prescriptions were also given during the course of the disease, each one containing small amounts of alcohol, and all were invariably followed by symptoms of alcoholism: flushing of the face, vertigo and even at times mild delirium. These symptoms were somewhat mitigated by diluting the dose with a large amount of water.

The husband informed me that his wife had never been able to drink even the weak Chinese wines containing only about 4 per cent. of alcohol without showing symptoms of intoxication so that eventually I took pains to give all medicines as powder or pill or in nonalcoholic solutions.

A number of nonalcoholic remedies were given, but in no case was there evident any sign of intoxication following their administration.

Canton Christian College.

A CASE OF CANCER FOLLOWING A SULPHURIC ACID BURN*

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So much is yet to be discovered concerning the circumstances surrounding the cause of cancer, that any new facts seem worthy of being reported. With this point in view, the following case, seen in a city clinic, is submitted.

REPORT OF CASE

C. M., a man, aged 57, employed in a dye factory, presented himself at the clinic with a prominent tumor on the dorsal surface of his right hand. Seven months prior to this, his hand had been burned by a few drops of sulphuric acid in a factory accident. Previously, the tissues in this region had, according to the patient, always been normal. The initial burn left a small ulcerated surface about the size of a pea which gave little pain, but which refused to heal. Three months later the patient noticed an increase in the size of the lesion, both in diameter and in height. Growth continued for the next four months.

Examination revealed a mass about 1½ inches wide and three-quarters inch high, presenting a reddish, ulcerated surface and a distinct red border. In the center, there was an orifice of a sinus from which a slight yellow discharge exuded, emitting a disagreeable odor. Pain was confined to the periphery, where it had been continuous for the past few months, increasing in intensity day by day. The axillary lymph nodes were not palpable at the time of examination.

The patient had been a man of regular habits, employed at outside work previous to obtaining his position at the dye factory two years before. He had always enjoyed good health, and his family history was negative.

The growth was excised by Dr. Van Ness of Newark, N. J., and sections of the specimen were made. Healing was slow at first, a black crust undermined with pus and sloughing material having formed. However, six weeks after the operation, the area started to fill in with healthy pink granulation tissue which slowly obliterated the excavated area. A microscopic examination revealed the fact that the tumor was an actively growing squamous cell carcinoma, the diagnosis having been confirmed by Dr. Francis Carter Wood of the Crocker Research Laboratory. When the patient was seen subsequently, the hand had almost entirely healed, but a hard, irregular, firmly attached mass, about the size of a hen's egg, was seen protruding from the inner anterior part of the right axilla, probably a metastasis involving the axillary lymph nodes. The new growth had started three months after the original tumor had been removed, and had rapidly progressed during the past five weeks. The patient was sent to the hospital for further treatment.

COMMENT

A great many other chemical irritants have been reported as factors in providing a site for the occurrence of a malignant growth. Tar and paraffin, for example, sometimes cause an acute eczema followed by a hyperplasia of the tissues which frequently forms a starting place for cancer. Soot by irritating the skin may cause an ulcer which later may develop into chimney-sweep's cancer. Tobacco in its combustion gives off certain irritant products which may lead to ulcers of the lip or tongue, and a resultant malignant growth. Workers handling guano and anilin dyes often get sores on exposed parts, which, in time, may become cancerous. Recently Fibiger has experimentally produced cancer of the stomach in animals as a result of chronic irritation by nematodes; and Yomagiwa has developed epithelioma of the skin in rabbits by irritation with tar.

In all these cases, as well as in the present one, the cancerous condition followed a chronic, slowly healing ulcer, which, in turn, was produced by the chemical irritation. It appears that the healthy cells are in some way altered by the ulceration so that if a predisposition to cancer is present, the malignant condition will follow. It is very unlikely in the present case that the acid itself was the etiologic factor in the production of the tumor, as thousands of sulphuric acid burns never become cancerous. A suggested explanation is that the acid burn and subsequent ulcerating condition merely provided a place of lowered resistance, which, combined with a certain predisposition and the "cancer age" of the patient, led to the development of the malignant growth.

* From Columbia University College of Physicians and Surgeons.

CEREBRAL GAS EMBOLISM OCCURRING DURING ADMINISTRATION OF ARTIFICIAL PNEUMOTHORAX

J. D. THOMAS, M.D., MOUNT VERNON, OHIO

History.—W. W., aged 37, white, machinist, native of Scotland, who had been in the United States four years, was admitted to the Ohio State Sanatorium for Incipient Pulmonary Tuberculosis, May 27, 1918, and his condition classified as moderately advanced (Turban II). He gave a history of having had tuberculosis ten years before, with several pulmonary hemorrhages at that time. He had recovered with no recurrence until April 1, 1918, when he developed a heavy cold which persisted. On admission he weighed 166 pounds, which was normal. He was 5 feet, 5 inches tall, stockily built, had a short, thick neck, and was of the typical apoplectic type.

Examination.—The sputum was positive for tubercle bacilli, May 31, July 23 and Dec. 10, 1918, and Jan. 4, 1919. The urine was negative on several different examinations. August 17, the sputum was streaked. On admission, the temperature ranged from normal to 99.4 F. until the middle of August, when it subsided to normal until October 8. At this time, the patient had an acute exacerbation ranging to 99.8 F. for a few days, when it again became normal. The pulse rate was always low, ranging from 54 to 70. The appetite was good, the bowels regular, and the patient felt comfortable all the time. There was considerable cough and expectoration. It was not possible to develop any stable degree of exercise, even under the most careful system of graduation.

Treatment and Result.—December 30, physical examination revealed evidence of a cavity formation in the right upper lobe which was confirmed by the roentgen ray. It was then decided to perform artificial pneumothorax. January 2, this was done, 350 c.c. of nitrogen gas being given in the fourth interspace, midway between the nipple and the sternum. The patient showed no disturbance and experienced no discomfort except slight soreness at the point of puncture. Cough and expectoration materially diminished after the first treatment. Subsequent treatments were given, as follows: January 2, 300 c.c.; January 18, 300 c.c.; January 25, 600 c.c.; February 5, 650 c.c.; February 17, 600 c.c., and March 3, 600 c.c. The patient was feeling very well and showed unmistakable signs of improvement.

March 14, after the usual procedure and with a manometer reading of from —3 to —7, about 100 c.c. of gas had been introduced, when the patient turned his head slowly, far to the right, saying, "There is something wrong." The face became cyanotic; the pupils were strongly contracted; the chin was drawn over the right shoulder; breathing was slow and stertorous; the eyes were drawn to the right; the entire body became quite rigid, with complete loss of consciousness and with tonic convulsions and frothing at the mouth. After

about eight minutes of convulsive movements, he relaxed and subsided into a semicomatose condition. Whenever aroused, he had a staring expression and would immediately relapse into a comatose state. There was complete loss of sensation and reflexes. The pulse rate was 54; respiration was 18, and was somewhat labored. During the night following this experience, the patient was quite restless, involuntarily throwing the bedding, moaning and sighing aloud, and frequently calling out and beating the bed with the right fist. Left side movements were wholly uncontrolled. He tried to get out of bed, but he could not coordinate his movements.

During the day of the fifteenth, he was still unconscious and very restless, moaning and talking incoherently all the time. He made an attempt to get out of bed, but fell on the floor and had to be lifted back. He had three involuntary actions of the bowels, and voided urine frequently and involuntarily. Toward evening, he became more quiet and seemed to show some return of consciousness. He had a quiet and restful night, and in the morning he was perfectly rational. The second day after this, he was allowed to get out of bed for a short time. The third day, he was up for all meals, and was about the cottage. On the fifth day, he was allowed to go to the general dining room, feeling as well as usual. He showed absolutely no untoward results from the experience and was discharged, April 27, as "quiescent."

REPORT OF A CASE OF VOLVULUS OF AN INTUSSUSCEPTION

E. L. ELIASON, M.D., PHILADELPHIA

History.—I. A., a negro, aged 22, was admitted to the hospital, July 3, complaining of pain in the right iliac region. On the preceding February 26, the patient had been operated on for acute appendicitis, and on June 17, for abdominal adhesions which were found and freed. On admission, July 3, 1916, the temperature was 97 F., the pulse 84, and respiration was 24. The abdomen was flat and soft. No tender areas and no masses were found. There had been no vomiting, and the bowels were regular and had moved the previous day. The patient stated that he had been having the same type of pain ever since his operation for adhesions, sixteen days before. He was given a simple enema, 1/60 grain of physostigmin (eserin) and morphin, with good results. The following day he felt relieved and was discharged.

Clinical Course.—July 13, the patient returned to the dispensary complaining of severe abdominal pain. He was again admitted and given 1/6 grain of morphin with no relief. Two hours later, he was given 10 grains of barbital, and a sterile water hypodermic by the resident physician, who suspected a hysterical element in the condition. The patient obtained relief and slept.

July 14, the temperature was 98, the pulse 80, and the respiration 24. The leukocyte count was 8,100. The patient's bowels had moved, and he had voided urine normally. He did not vomit or feel nauseated, but, on the contrary, ate soft diet with relish and asked for more. The abdomen was soft, showed no distention, and auscultation elicited normal peristaltic sounds. The urine showed no blood, but did show marked indican reaction. The bowels moved as a result of a soapsuds enema, and were normal macroscopically.

July 15, the night nurse's report for 1 a. m. was to the effect that the patient was quiet and had been sleeping most of the night. His temperature was 98.2 F., and pulse 80. The nurse's 2 a. m. report stated that the patient was having severe pains and was tossing about the bed, groaning and perspiring profusely. The patient later got out of bed in the nurse's absence and was found in the hall on the floor, crying out with pain. When I saw him for the first time at 10 a. m., he gave every evidence of being hard hit by some abdominal catastrophe. The skin was cold and clammy. The temperature 96 F. and the pulse 120. He was groaning with pain and was in a state of collapse. Abdominal examination revealed a tender mass in the left iliac fossa.

Operation.—A midline incision was made, and a mass was delivered which proved to be a volvulus of the ileum, undergoing gangrene. When the volvulus was untwisted, the loop was found to consist of an intussusception of the ileum, the intussuscepting loop being glued tightly with well formed adhesions to the intussuscepted loop. These adhesions were too firm to separate. Owing to the extreme condition of the patient, the diseased intestine was excised and the two ends of the normal ileum brought out of the wound and left open. The wound was closed. The patient died ten hours later.

COMMENT

Examination of the removed intestine revealed beginning gangrene of the enveloping loop of the volvulated intussusception. The inner loop was in the last stage of gangrene and just ready to slough off into the bowel. Nature had made a firm anastomosis at the point of entrance of the one loop into the other. Judging from the advanced decomposition of the inner loop, the conclusion had to be drawn that the intussusception had existed for days, probably since his first symptoms seventeen days before, while the outer loop showed only evidence of strangulation of hours' duration. In all probability the volvulus occurred at 1 a. m. of the morning of the operation, thus accounting for the patient's sudden collapse.

330 South Sixteenth Street.

AN ETHER DROPPER

I. E. HILL, M.D., HANNIBAL, MO.

One of the petty annoyances of the anesthetist is the arranging of a satisfactory dropper for the ether can.

Every one who gives many anesthesias, at some time or other, has wished for a device of some sort that would do

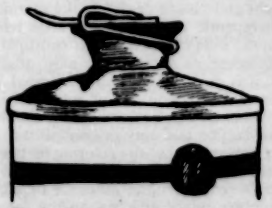


Fig. 1.—Top of ether can, with dropper.

away with the inserting of the wick of gauze, safety pin or similar makeshift dropper, and at the same time deliver the ether from the can in a suitable manner.

Fig. 2.—Photograph and schematic drawing of dropper in position on ether can.

After experimenting with many droppers, I have evolved a simple contrivance which not only eliminates all this trouble but at the same time adds a tinge of fascination and gives a finished technic to ether administration.

The dropper is made of thin sheet metal and is triangular, with the base covering half the mouth of the can. To the back of the metal is a wire spring loop which allows it to be instantly applied or removed. Whether the entire metal cap is cut out or two holes simply punched in it, the dropper will serve with equal satisfaction.

Therapeutics

A Department Devoted to the Improvement of Therapy. A Forum for the Discussion of the Use of Drugs and Other Remedies in the Treatment of Disease.

USE AND ABUSE OF CATHARTICS*

(*Continued from page 1885*)

SENNA

As a purgative, senna is more powerful than cascara sagrada, and often acts when the latter fails. It requires from four to eight hours for action. Large doses are therefore better given in the morning; small doses may be administered at bedtime. It is much more prone to produce griping, and in some patients to cause a feeling of abdominal soreness. On the principle that the mildest is the best, cascara is to be preferred to senna, especially for prolonged use. When, however, a single prompt, thorough evacuation is aimed at, senna is the superior.

Roentgenoscopic examination has demonstrated that senna exerts its chief effect on the large intestine. The movements of stomach and small intestine are not markedly changed; but, the moment the bismuth meal passes the ileocecal valve, it traverses the colon in great haste. This makes senna useful to complement the action of duodenal purgatives, such as the mercurials, and shows the rationale of the old prescription of blue mass at night and "black draft" in the morning.

From therapeutic doses there is little tendency to hypercatharsis, inflammation, or to constipation after its use. However, as senna is the most drastic of the purgatives, it is particularly contraindicated in spastic constipation and in conditions of intestinal inflammation. For patients with hemorrhoids it should be prescribed with caution and only in small doses.

We must remember that the coloring matter of senna gives to acid urine a deep yellow color, and that this urine becomes red under the influence of alkali. The latter appearance might give rise to the false fear of the presence of hematuria. Some of the cathartic principle is eliminated into the milk of nursing women. Hence, purging the mother may also purge the nursling.

The taste of senna, though bitter, is not nearly as intense as that of cascara sagrada; and it is more easily disguised. Thus the official *syrup of senna*, containing 25 per cent. of the fluidextract and flavored with coriander, is sufficiently pleasant for most children to take without protest. The *aromatic syrup of senna* of the National Formulary is still more pleasant and only of half the strength (12.5 per cent.), though it also contains, and probably unnecessarily, 5 per cent. of jalap, 1.75 per cent. of rhubarb, and 30 per cent. of alcohol. It is flavored with cinnamon, cloves, nutmeg and lemon. A teaspoonful of the official syrup or two teaspoonfuls of the aromatic would be sufficient to act on a sensitive adult or an older child. A 1-year-old babe would be acted on by 15 drops of the National Formulary preparation. As these syrups are readily available, it is surely, to say the least, inexpedient to prescribe such nostrums as "castoria" and "syrup of figs," which owe their value chiefly to senna.

In coffee or prune juice the taste of senna is hardly noticeable. It is recommended that senna leaves (2 gm.) be added to ground coffee (8 gm.) and infused with 90 c.c. each of hot coffee and hot milk; or else a teaspoonful of senna leaves be tied up in a small muslin bag and stewed with 250 gm. of prunes, in either case adding sweetening to taste. Senna forms the laxative ingredient of nearly all the various "herb teas," so much used by grandmothers. In these days of the automobile and the aeroplane, however, the slow and tedious, even though economical process of domestic extraction, is bound to become obsolete. Coffee or prune juice may more readily be made purgative by the addition of a dose of syrup or of fluidextract of senna.

The most pleasant way of taking senna is to use the powdered leaves, letting the alimentary tract do its own extracting. Thus, the *compound powder of glycyrrhiza* owes its popularity to its rather pleasant taste. It contains 18 per cent. of senna, glycyrrhiza and sugar for sweetening, and oil of fennel for flavoring. The sulphur contents (8 per cent.), would probably not be missed if it were deleted from the formula; for sulphur is a very feeble agent as compared with senna. The dose of compound powder of glycyrrhiza for an adult is a teaspoonful or more stirred up with water. For children, the dosage given in the accompanying tabulation may be employed.

DOSAGE OF COMPOUND POWDER OF GLYCYRRHIZA FOR CHILDREN

Age of Child	Gm.
6 months	0.60
1 year	0.90
2 years	1.20
3 years	2.00
5 years	3.00

The *confection of senna* was very properly deleted from the present pharmacopeia. By no stretch of the imagination could it have been called a confection in the modern sense. A more pleasant preparation can be made in any household after the subjoined formula, which will yield a candy medication of approximately the same strength and dose as the compound glycyrrhiza powder.

LAXATIVE FRUIT CAKE

Senna leaves	Of each, equal parts
Figs	
Dates (freed from stones)	
Prunes (freed from stones)	
Raisins (seedless)	

Chop fine in a chopping bowl, mix by kneading, roll into cylinders as thick as a thumb.
Dose: 1 slice, larger or smaller according to size of the patient.

Perhaps the very pleasantness of this preparation is a disadvantage, as it may invite unnecessary use, and thus lead to the pernicious practice of habitual catharsis.

The *fluidextract of senna* might be used in a manner similar to that of cascara sagrada and for the same purpose—to increase intestinal irritability—in the curative treatment of chronic constipation, in doses of from 0.5 to 1 c.c. several times daily, and progressively reduced; or else in dose of from 2 to 4 c.c. for a single thorough evacuation. The addition of from 0.25 to 0.50 c.c. of tincture of belladonna to each dose, to antagonize griping, is suggested, though the patient may object to the dryness of the mouth and the impairment of vision produced thereby.

Little can be said in favor of the old abominably tasting "black draft," the *compound infusion of senna*, excepting on the score of its efficiency. It is a relic of the days, fortunately now past, when nauseous medicine was given by the teacupful. The combination of senna (6 per cent.), which is chiefly a stimulant to per-

* This is the eleventh of a series of articles on the pharmacology, physiology and practical application of the common laxatives and cathartics. The first article appeared October 18.

istalsis, with magnesium sulphate (12 per cent), which keeps the feces fluid but does not have much effect on the musculature, is an instance of good synergism. The manna (12 per cent.), on the other hand, is too feeble in activity and in taste to be of much value either as an adjuvant or as a corrective. Fennel is used as flavoring. The average dose of 120 c.c. of this preparation will open the bowels, if it is within the power of any cathartic to do so. It might be remembered as a last resort, when other cathartics have failed and intestinal obstruction is probably not present. When it fails, a strong suspicion of mechanical interference with intestinal evacuation may be entertained. Of course, when intestinal obstruction is known to be present, this powerful agent is decidedly contraindicated, as it is more dangerous than the surgeon.

(To be continued)

New and Nonofficial Remedies

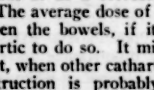
THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION. W. A. PUCKNER, SECRETARY.

BENZYL BENZOATE (See N. N. R., 1919, p. 53).

Benzyl Benzoate for Therapeutic Use—Van Dyk and Company.—A brand of benzyl benzoate which complies with the N. N. R. standards.

Manufactured by Van Dyk and Co. No U. S. patent or trademark.

LUMINAL. — Phenobarbital. — Phenyl-Ethyl-Barbituric Acid.—Phenyl-Ethyl-Malonyl-Urea.



2,4,6-trioxy-5-phenyl-ethyl pyramidin. Phenobarbital (luminal) differs from barbital (veronal) in that one ethyl group (C_2H_5) has been replaced by one phenyl group (C_6H_5).

Actions and Uses.—It is claimed that the introduction of the phenyl group increases the hypnotic power of luminal (phenobarbital) over that of barbital.

Luminal is said to produce sleep in the cat and dog with a satisfactory range between the effective and lethal doses, affording a deep, quiet sleep, without injury to the respiration or circulation. Very rarely a period of excitement precedes sleep.

It has a sedative action on respiration, lessening the frequency of breathing, although the volume of each respiration is increased. It kills by respiratory paralysis. It is eliminated by the kidneys, a certain portion being probably decomposed in the organism. No renal injuries or gastric disturbances have been observed.

Luminal is claimed to be a useful hypnotic in nervous insomnia and conditions of excitement of the nervous system.

Dosage.—From 0.2 to 0.3 Gm. (3 to 5 grains) increased if necessary to 0.8 Gm. (12 grains). A maximum dose of 0.8 Gm. (12 grains) should not be exceeded. Smaller doses are sometimes efficient.

Manufactured by the Winthrop Chemical Co., Inc., New York. U. S. patent No. 1,025,872 (May 7, 1912; expires 1929). U. S. trademark No. 87,327.

Luminal Tablets 1½ grains.—Each tablet contains luminal 1½ grains.

Luminal is a white, odorless, slightly bitter powder. It is almost insoluble in cold water, slightly soluble in hot water; soluble in alcohol, ether and chloroform, and in alkaline solutions. It crystallizes from boiling water in lustrous leaflets and is precipitated unchanged by acids from its alkaline solutions. An aqueous solution of luminal has an acid reaction to litmus.

Luminal melts not below 172 C.

Shake about 0.3 Gm. of luminal for a short time with 1 Cc. of normal sodium hydroxide and 5 Cc. of water, filter the mixture. Divide the filtrate into two portions and add mercuric chloride test solution to one and silver nitrate test solution to the other. A white precipitate is given in each case.

Boil about 1 Gm. of luminal for five minutes in 10 Cc. of a 50 per cent. solution of sodium hydroxide. Ammonia is evolved.

Dissolve about 1 Gm. of luminal in 5 Cc. of normal sodium hydroxide and heat the solution for four hours on a boiling water bath, replacing the evaporated water from time to time. Crystals of phenylethylacetyl urea separate on cooling. After recrystallization from dilute alcohol these crystals melt at 147 C.

Dissolve about 0.1 Gm. of luminal in 1 Cc. of concentrated sulphuric acid. The solution is colorless. Incinerate about 0.5 Gm. of luminal accurately weighed. The ash amounts to not more than 1 per cent.

LUMINAL-SODIUM. — Phenobarbital Sodium. — Sodium Phenyl-Ethyl-Barbiturate. — Luminal Soluble. — $Na(C_{12}H_{11}N_2O_3)$.—The monosodium salt of phenyl-ethyl-barbituric acid.

Actions and Uses.—The same as those of luminal.

Dosage.—For hypodermic injection luminal-sodium is used in the form of 20 per cent. solution, prepared by dissolving the salt in boiled and cooled distilled water; 2 Cc. (30 minims) of the solution contain 0.4 Gm. (6 grains) of luminal-sodium. The dose of luminal-sodium is 10 per cent. greater than that of luminal.

Luminal-sodium may be given hypodermically in doses of 0.1 to 0.3 Gm. (1½ to 5 grains).

Manufactured by the Winthrop Chemical Co., Inc., New York. U. S. patent No. 1,025,872 (May 7, 1912; expires 1929). U. S. trademark No. 87,327.

Luminal-sodium is a white, hygroscopic powder; very soluble in water; soluble in alcohol; practically insoluble in ether and chloroform. An aqueous solution of luminal-sodium has an alkaline reaction to litmus. On long standing or prolonged boiling of the aqueous solution 1 molecule of carbon dioxide is liberated and phenylethylacetyl urea is precipitated; after recrystallization from dilute alcohol this substance melts at 147 C.

Incinerate about 0.5 Gm. of luminal-sodium. The residue responds to tests for sodium carbonate.

Acidify an aqueous solution of luminal-sodium with hydrochloric acid and shake with ether. Evaporate the solvent. The residue responds to tests for luminal (which see).

One Gm. of luminal-sodium dissolves without residue in 20 Cc. of alcohol (distinction from barbital sodium, which requires more than 500 Cc. of alcohol for solution).

Dry about 1 Gm. of luminal-sodium accurately weighed to constant weight over sulphuric acid. The loss does not exceed 5 per cent.

SAJODIN. — Calcium Monoiodobehenate. — $(C_{21}H_{41}ICOO)_2Ca$.—The calcium salt of monoiodobehenic acid.

Actions and Uses.—Sajodin is used as a substitute for iodides. The iodine of sajodin, being longer retained, is perhaps better utilized. It is also less liable to produce gastric disturbances.

Dosage.—From 1 to 3 Gm. (15 to 45 grains) daily.

Manufactured by the Winthrop Chemical Co., Inc., New York. U. S. patent No. 839,509 (Dec. 25, 1906; expires 1924). U. S. trademark No. 61,730.

Sajodin Tablets, 8 grains.—Each tablet contains sajodin 8 grains.

Sajodin is a colorless or slightly yellow powder, odorless, tasteless, unctuous to the touch, insoluble in water, very slightly soluble in cold alcohol and in ether, and freely soluble in warm chloroform. When heated, it chars and gives off violet vapors of iodine and finally a residue of calcium oxide remains.

Shake 0.5 Gm. thoroughly with 10 Cc. boiling water and filter. The filtrate is neutral to litmus (lime) and gives but a slight opalescence with silver nitrate solution (soluble iodides). Five Cc. of the filtrate when evaporated leaves no weighable residue (soluble salts).

Dissolve 0.5 Gm. in 5 Cc. warm chloroform. The solution is clear or but slightly opalescent and only a trace of solid matter separates within 2 hours.

Ignite 0.5 Gm. sajodin. The residue dissolves completely in hydrochloric acid and this solution made alkaline with ammonia water yields a precipitate on addition of ammonium oxalate (calcium). Strongly ignite about ½ Gm. of sajodin accurately weighed: the ash is not more than 6.2 per cent.

Dry about 1 Gm. sajodin accurately weighed to constant weight at 100 C.: the loss is not more than 2 per cent. (limit of moisture).

Ignite thoroughly an accurately weighed quantity, about 2 Gm., previously dried at 100 C. Extract the ash with hot dilute hydrochloric acid. To the acid solution add ammonia water in slight excess and then an excess of ammonium oxalate solution, collect the precipitate, ignite to calcium oxide in the usual manner and weigh. The per cent. calcium is not more than 4.2.

To about 1 Gm. sajodin dried at 100 C. and accurately weighed, and contained in a 500 Cc. Ehrlenmeyer flask add 50 Cc. half-normal alcoholic potash solution. Heat for two hours under a reflux condenser. Remove the condenser, boil off the alcohol taking care to avoid loss by bumping and transfer the residue to a separator using at first warm water but finally a little diluted nitric acid to insure complete transfer of the iodide to the separator. Cool the contents of the separator and add 50 Cc. of ether and sufficient diluted nitric acid to decompose the soap. If the solution becomes yellow from liberation of iodine add a little sodium sulphite to reduce the iodine. Shake thoroughly and draw off the acid layer through a wet filter, into a 500 Cc. flask. Wash the ether in the separator with three separate portions of water of 25 Cc. each, adding these through the filter to the acid solution in the flask, the volume of which should now be about 200 Cc., warm to expel dissolved ether, cool and add 5 Cc. of concentrated nitric acid and at once 25 Cc. tenth-normal silver nitrate solution. Titrate the excess of silver with tenth-normal sulphocyanate, using ferric ammonium sulphate as indicator. The volume of tenth-normal silver used indicates not less than 24.5 per cent. of iodine. Each Gm. of sajodin corresponds to not less than 19.3 Cc. tenth-normal silver nitrate solution.

The iodine content of sajodin may also be determined by the Carius method, using about 0.5 Gm. of sajodin.

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SATURDAY, DECEMBER 27, 1919

CHLORINATION OF WATER SUPPLIES

The chlorination of water supplies is probably the most important contribution made by this country to the art of water purification. In fact, this process stands out as the most useful procedure yet devised for insuring the safety of a municipal water supply. The results that could be achieved by adding calcium hypochlorite to water were first demonstrated in some experiments by G. A. Johnson at the Union Stock Yards in Chicago. Immediate publicity was given to this work by the treatment of the Jersey City supply at Boonton and the celebrated lawsuit that followed. The next few years witnessed a rapid development in the installation of plants using calcium hypochlorite, approximately 500 of these being in operation at the end of 1911. Disadvantages in the use of the lime salt soon appeared, due primarily to the lack of uniformity in the strength of the commercial product and also to the loss of germicidal efficiency, following storage of this chemical. These disadvantages were in large part overcome by the introduction of liquefied chlorin gas, or "liquid chlorin." Greater precision and uniformity of application became possible through this means, and the use of the liquid chlorin cylinders has practically displaced the bleaching powder. It is estimated that at the end of 1918 approximately 2,500 water purification plants in the United States were being operated with the use of liquid chlorin.

While few sanitary engineers believe that chlorination is a substitute for filtration, there is general agreement that, as an adjunct to the filtering process and to meet emergency conditions, chlorination is almost indispensable for many supplies. The expense is low and amounts to only about 40 cents per million gallons of water treated, or, for a municipality of 5,000, only about $150 a year, including depreciation.

The principal objection to water chlorination has been the occasional production of disagreeable odors or tastes. This is partly a matter of psychology: in many places where chlorination has been practiced and where newspapers have not taken up the matter in a sensational way, there has been no material objection on the part of the consumers. The interesting experience of the city of Milwaukee[1] shows that the occurrence of unpleasant odors in a water supply may be chargeable only in part to the chlorin. In that city it was found that the sewage was laden with coal tar derivatives and that the odor was primarily due to these substances, perhaps acted on by the chlorin. The extremely disagreeable taste in the Milwaukee water vanished altogether when sewage from a coke plant was diverted from the lake, although chlorination was continued. It seems likely that in other cases in which the chlorin itself has been accused, the presence of other substances, especially the coal tar derivatives, has been essentially responsible.

The remarkable decline in typhoid fever in American cities in the last ten years has been clearly set forth in the annual statistical summaries published by THE JOURNAL; and some sanitarians, especially waterworks engineers, have been inclined to attribute this improvement solely to water chlorination. This is probably an extreme view, since other factors, such as the growth in milk pasteurization, have been operative during the same period to reduce typhoid prevalence. Even, however, if it is impossible to ascribe all the credit for typhoid diminution to water chlorination, it is enough to say that this procedure has had a large share in the improvement effected. If it were still more widely used, especially in the smaller towns and cities using surface water without filtration, there is no question that a further impetus would be given to the work of typhoid prevention in the United States.

IS ALCOHOL A STIMULANT?

Until comparatively recently, alcohol was regarded as a respiratory and cardiac stimulant. Whisky was probably the most popular domestic remedy for such occasional upsets as fainting, in which stimulation was presumably required. The popular idea that alcohol is a tone stimulant has so often proved to be untenable on the basis of scientific evidence that it seems almost superfluous to refute the mistaken notion anew. No one will deny that a feeling of relief often follows the use of alcohol in conditions in which stimulation seems to be indicated. In such cases, however, it has been shown to act merely as an irritant to the mucous membranes of the mouth and throat, promoting thus a beneficent local reaction before the alcohol has had time to be absorbed and stimulate in any way the depressed function.

There would be little occasion to refer again to the subject at this time had not a layman of prominence, Mr. G. E. Flint, recently, in a fiery volume,[2] vigorously defended alcohol as a stimulant. Any tyro in physiol-

1. J. Am. Waterworks Assn. 6: 515, 1919.
2. Flint G. E.: The Whole Truth About Alcohol, with an Introduction by Dr. Abraham Jacobi, New York, the Macmillan Company, 1919.

ogy can find contradictions in Flint's book which, as a recent reviewer[3] remarked in THE JOURNAL, "sometimes quotes confidently as fact what is absolutely not true." Consider, for example, this statement (page 155):

> That alcohol is very easily digested is proved by the fact that the carbohydrates cannot be digested as such, but only after they have been changed into sugar and finally into alcohol.

To the author of such statements, seemingly endorsed by a medical expert, alcohol is distinctly a "heart stimulant." And then there is further instruction: "That alcohol is not a stimulant has never been proved."

In animal experimentation the use of anesthetics, which are commonly employed to insure painless effects in such studies, may interfere with the interpretation of the observations in which alcohol, itself a narcotic, is concerned. Lately, satisfactory methods of investigation without the use of the anesthetic when alcohol is being tested have been devised. Hyatt,[4] who has given the most recent report, found that when alcohol is given by mouth there is a rapid rise in blood pressure followed by an immediate return to normal. This is a purely local effect due to irritation of the gustatory nerves and swallowing movements. The same result can be obtained with dilute acids. When the alcohol was introduced directly into the circulation without preliminary contact with mucous membranes, there was either no effect or a fall in pressure. An anesthetic dose may actually be given by introduction in this manner into the circulation, to which it must find its way in any mode of administration, without any stimulation of the heart or respiration. Even when moderate doses of 40 per cent. alcohol are introduced into the stomach slowly by the use of a gastric sound, no change in pressure is produced.

These experiments confirm the earlier studies of the same sort which Brooks[5] has described in THE JOURNAL. Why need the subject receive further argument? In refuting the claim that alcohol is in any sense a direct stimulant of the heart, a distinguished British committee reporting to the Central Control Board thus formulated[6] the status of the controversy:

> The fact that the beneficial effect appears almost immediately and long before any significant amount of alcohol can have been absorbed and carried to the heart, is evidence for this local and indirect nature of the action. Its use in these circumstances is, therefore, comparable with that of smelling salts, or the irritating fumes of burnt feathers, traditionally employed for the same purpose. When, in conditions of more protracted weakness of the heart, the administration of alcohol has a beneficial effect, this must be attributed mainly to its mildly narcotic and sedative action, relieving the centers which modify the action of the heart from the disturbing influence of pain and anxiety. The promotion of a patient's comfort, the relief of mental strain, may be an essential element in the treatment of disease, and an important factor in recovery. It does not, however, justify the description of alcohol as a "stimulant" of the heart.

3. Book Notices, J. A. M. A. 73:1004 (Sept. 27) 1919.
4. Hyatt, E. C.: The Action of Alcohol on the Heart and Respiration, J. Lab. & Clin. Med. 3:56 (Oct.) 1919.
5. Brooks, Clyde: The Action of Alcohol on the Normal, Intact Unanesthetized Animal, J. A. M. A. 55:372 (July 30) 1910.
6. Alcohol: Its Action on the Human Organism, London, H. M. Stationery Office, 1918, p. 76.

THE DETERMINATION OF RACIAL RELATIONSHIPS BY MEANS OF BLOOD

The question of the relationship of different races to one another is a matter of considerable interest. Up to the present, morphologic criteria have been used almost exclusively in attempts to decide what this relationship is. Various anthropometric tests have been devised, for example, the so-called cranial index, the facial angle, and similar tests. These tests are in a sense as obvious as differences in stature, and such striking differences in conformation as the peculiarities in the eye slits which characterize the oriental races. With the advent of immunologic knowledge, the methods of serology were applied to the study of racial peculiarities. In the early days of serology, the precipitin test was used to demonstrate the blood relationship between man and the higher apes. The possibility of differentiating groups within the same species was not apparent until some time after serology became well established. Indeed, it was not until Landsteiner demonstrated the fact that serologic differences occurred among individuals of the same species that the possibility of using serologic methods became apparent.

In certain fields of operation in connection with the recent war, extraordinary opportunities were offered for the study of different races on account of the bringing together of military units from various parts of the world. In the British campaign in Mesopotamia, particularly, an extremely cosmopolitan group was collected. Advantage of this was taken by L. and H. Hirschfeld,[1] two Swiss serologists, who made extensive studies of the blood of soldiers of different nationalities and of the population of Mesopotamia. The type of blood test chosen was that in every day use in connection with the transfusion of blood, namely, the determination of the group into which individuals should be placed with reference to the presence of iso-agglutinins. The method as ordinarily used places individuals in one of four groups. The Hirschfelds tested English, French, Italian, Serbian, Greek, Bulgarian, Russian, Arabian, Turkish, Senegalese, Anamese and Indian soldiers, and also tested the blood of Jewish refugees.

As the result of a great many tests, the observers were able to divide the nationalities into three groups: a European type, which contained the English, French, Italians, Greeks, Bulgarians and Serbians and which,

1. Hirschfeld, Ludwik, and Hirschfeld, Hanka: Serological Differences Between the Blood of Different Races, Lancet 2:675 (Oct. 18) 1919.

according to the studies of Landsteiner and von Dungern, would also contain the Germans and Austrians; an intermediate group containing the Arabs, Turks, Russians and Jews, and an Asio-African group containing the negroes, East Indians, and natives of Indo-China and Madagascar. The authors draw the conclusion that these results are suggestive of a dual origin of the human race. According to this conception, the European type and the Asio-African type originated independently, and the intermediate type represents the fusion of the other two types. The validity of these conclusions may, of course, be questioned; but the studies are certainly of interest not only on account of the immediate results but also because they suggest further studies of different races along serologic lines.

HEMOGLOBIN DETERMINATION

The method for the determination of the hemoglobin content of the blood introduced by Sahli is probably one of the most commonly used today. The method is fairly reliable and the apparatus required is not complicated; it consists of a simple color standard (usually acid hematin) and a calibrated tube in which the measured amount of blood is treated appropriately for comparison. Clinical chemists have recognized, however, that the Sahli method is open to certain objections: the inaccuracies due to the variations in the calibrations and in the construction of the tubes; the fading of the standard;[1] the variations of the readings in different lights; the delay in the development of the permanent color, and the "personal equation."

About two years ago, Palmer[2] suggested converting the hemoglobin to carbon monoxid-hemoglobin and comparing this with a standard solution of like composition. The comparisons were made in a colorimeter, a modification that enhanced greatly the accuracy and ease of the determination. Since then Cohen and Smith[3] of the Yale Station of the Chemical Warfare Service have shown that the Palmer method is deficient in one particular: Palmer recommended artificial gas for his source of carbon monoxid; Cohen and Smith noted that the standard made at New Haven deteriorated, most likely owing to the use of an unusual quality of illuminating gas. Hence they have proposed a modification of the Palmer method by reverting to the original Sahli standard but retaining the valuable technical features of the Palmer procedure. By means of check determinations, for which the complex Van Slyke[4] apparatus was used as a control, the Sahli-Palmer modification was shown to be accurate within 2 per cent., even in the hands of relatively inexperienced workers. Its limitations are that a special form of colorimeter is required, and due time must be allowed for the full development of the acid hematin color.

Berman[5] has just proposed an acid hematin method, modifying the Sahli procedure slightly in two respects: Instead of diluting the hemoglobin standard with part water and part tenth-normal hydrochloric acid solution, the dilution is made entirely with tenth-normal acid solution, and after dilution, the acid-hemoglobin mixture is boiled one minute to hasten the formation of the maximum depth of the acid hematin color. According to the author's data, the accuracy of the latter method may be kept within 3 per cent. It is doubtful whether the many laboratory users of the Palmer method will wish to return to the brownish acid hematin color in preference to the beautiful and easily contrasted pink color of the carbon monoxid-hemoglobin; perhaps the difficulty may be solved by a refined method of securing a satisfactory grade of carbon monoxid.

1. Kuttner, Theodore: Hemoglobin Estimation, J. A. M. A. **68**: 1370 (April 29) 1916.
2. Palmer, W. W.: Colorimetric Determination of Hemoglobin, J. Biol. Chem. **33**: 119 (Jan.) 1918; Laboratory Methods of the U. S. Army, Medical War Manual 6, p. 132.
3. Cohen, Barnett, and Smith, A. H.: The Colorimetric Determination of Hemoglobin, J. Biol. Chem. **39**: 489 (Oct.) 1919.
4. Van Slyke, D. D.: Gasometric Determination of the Oxygen and Hemoglobin of Blood, J. Biol. Chem. **33**: 127 (Jan.) 1918; Medical War Manual 6, p. 129.
5. Berman, Louis: The Determination of Hemoglobin by the Acid Hematin Method, Arch. Int. Med. **24**: 553 (Nov.) 1919.
6. Fishberg: Am. Rev. Tuberc. **3**: 532, 1919.

Current Comment

A REMINDER

A blue slip to be used in remitting subscriptions and Fellowship dues for 1920 is inserted in THE JOURNAL this week. Last week we explained its use under the heading "Will You Help?" The use of this slip by Fellows and subscribers will result in a considerable saving for the Association on the cost of sending individual statements. In each of the several years past, more than 20,000 subscribers and Fellows utilized similar slips, and it is hoped that even a larger number this year will give their cooperation in this matter. Little things promptly performed constitute most of life's courtesies.

INFLUENZA AND TUBERCULOSIS

The reappearance of influenza a year ago led to the prediction by many writers that a marked increase in active pulmonary tuberculosis was sure to ensue. Following the epidemic of 1889-1890, a number of articles appeared in which the statement was made that influenza frequently caused a lighting up of quiescent tuberculosis. This view became current with the medical profession and led to the foregoing prophecy. Some recent observations of Fishberg[6] seem to indicate that a decided revision of our views is necessary. Fishberg points out that when a patient with tuberculosis states that the onset of his disease followed influenza, it is very necessary to determine just what the patient means by influenza. The terms "grip" and "influenza"

are used so loosely by both the layman and the physician that what the patient describes as influenza is frequently not true epidemic influenza at all but an ordinary upper air passage infection such as is likely to occur at any time. Furthermore, the early symptoms of tuberculosis itself may take the form of just such an upper air passage infection. The question is also complicated by the fact that many of us have not yet learned to differentiate pulmonary tuberculosis from the postinfluenzal pulmonary lesions that simulate it. Fishberg's conclusions, and they are supported by evidence from other observers, rather indicate that patients with tuberculosis are as resistant to influenza as the average individual, that they develop pulmonary complications possibly less frequently than the nontuberculous, and that the ultimate effect of an attack of influenza, in most instances, is not to cause the tuberculosis to light up. Fishberg's article is timely and calls attention to the necessity for a critical analysis of the late complications of influenza. We are inclined to believe, however, that it is as yet somewhat early to decide whether as radical a change of opinion is warranted as his article would indicate.

A QUARTER CENTURY OF SERUM THERAPY IN DIPHTHERIA

In a recent address before the Académie de médecine of Paris, Louis Martin[1] recalled that in September, 1894, Roux communicated to a medical congress in Budapest the results of his pioneer studies on the serum therapy of diphtheria. To physicians of the present generation it seems long ago that Behring and his collaborators, Kitasato and Wernicke, definitely showed that the cell-free blood serum of animals immunized with diphtheria toxin acquires the power to protect other animals of the same and different species against the poison. Yet, in the quarter century that has elapsed since Roux put to the test of human clinical experience the treatment discovered by Behring, what enormous practical advantages to mankind have been derived from these brilliant scientific investigations. The outcome with the first larger group of diphtheria patients who received no other medical treatment than administration of antidiphtheritic serum was so striking that the procedure found prompt recognition from clinicians. Serum therapy in diphtheria became an accepted method. It is unnecessary to dwell on the fact that the mortality in this disease has been reduced from 30 per cent. or more to 8 per cent. or less in practice. The beneficent results can be learned from the experience of every community in the civilized world. The maximum of therapeutic efficiency has not yet been reached. With speedier diagnosis, with more direct methods of introducing the antitoxin, with better concentration and preparation of the latter, and with more heroic dosage in emergencies, the results seem destined to become even more favorable than they have been in the past. Now that the war is over and men can once more turn their thoughts to activities that are worth while, let us remember that the discovery of diphtheria antitoxin was not an overnight affair or a chance find. Only patient, laborious researches brought ultimate success. In the study of diphtheria, by which such brilliant results have been achieved, the laboratory and the clinic have worked hand in hand. Looking forward to further great discoveries in the domain of medicine, let us not fail to encourage in the case of other diseases likewise this fruitful collaboration between science and practice.

1. Martin, Louis: Vingt-cinq années de sérothérapie antidiphthérique, Bull. de l'Acad. de méd. 82:173 (Oct. 14) 1919.

THE ORIGIN OF MACROPHAGES

In his earliest explanations of cell ingestion, or phagocytosis, of foreign particles, Metchnikoff pointed out that the process is quite comparable to what takes place in the intracellular digestive functions among unicellular forms of life. In the lowest animals the single cell must perform all necessary functions, whereas in the course of evolution to the higher forms a division of labor has taken place, which is expressed by a differentiation in structure and activity. Bearing in mind the evolutionary history of the cells, we should not be surprised if various types of cells besides the specialized leukocytes could, if occasion arose, assume the primitive function of cell ingestion. Metchnikoff[1] has, indeed, distinguished between the "motile" and "fixed" phagocytes, the former the leukocytes of the circulating blood, the latter certain connective tissue cells, endothelial cells, cellular elements in the lymph nodes and spleen pulp; in fact, all phagocytic cells that are ordinarily confined to some definite locality in the body. Among phagocytic cells Metchnikoff further distinguished between "microphages," by which he designated the polymorphonuclear leukocytes of the circulating blood, and "macrophages." The latter include the fixed cells mentioned, together with the large mononuclear elements of the blood. Following his conceptions still further, we may regard the macrophages as concerned primarily with the engulfing of cellular detritus and foreign particles, whereas the microphages are more commonly engaged in the resorption of bacteria. The origin of these phagocytic cells, between which no sharp division of classification can be drawn, has been the subject of considerable speculation. Are they derived from connective tissue, endothelium or lymph cells, to all of which they have at times seemed to bear some relation? What is the identity of the various phagocytic cells which have received a diversity of new names in recent years and which seem to be so important in the defense against certain pathologic processes in the organism? With respect to some of them, several investigators have reached the conclusion that, as lymphocytic cells do not possess the power of phagocytosis, the macrophages are derived from connective tissue. Recently, however, Foot[2] has championed the view that the macrophages of the loose connective tissue are in

1. A discussion of his views will be found in Zinsser, H.: Infection and Resistance, New York, the Macmillan Company, 1914, chapter on phagocytosis.

2. Foot, N. C.: Studies on Endothelial Reactions: The Macrophages of the Loose Connective Tissue, J. M. Res. 40:353 (Sept.) 1919.

reality of endothelial origin. From studies conducted in the department of pathology at the Harvard Medical School, he concludes that they do not originate in the omentum or the connective tissue cells, or from lymphocytes. According to Foot they are probably derived from the proliferating vascular endothelium in the immediate vicinity of the lesion that calls them forth, rather than from the vascular endothelium in general.

NEW NURSING LEGISLATION PROPOSED FOR NEW YORK STATE

Since the influenza epidemic of last year with the accompanying shortage of nurses, much discussion has ensued relative to proposed reforms in nursing legislation in order to make available an adequate supply of nurses, not only for ordinary times but also for times of stress. THE JOURNAL has received a copy of a bill which it is proposed to introduce into the 1920 legislature of New York as an amendment to the present law covering nursing. The main features of this bill are the statement of definite qualifications for those carrying the title R. N., and an annual reregistration. A new class to be known as trained attendants, with the designation T. A., is created; it is to include persons over 18 years of age holding a certificate from a school for trained attendants connected with any institution, properly licensed, giving a course of at least nine months, including six months of practical experience. Trained attendants are also to reregister annually. In addition to those licensed as trained attendants with the qualifications mentioned, the regents may license any one who pays a fee of $5 and submits satisfactory evidence that she is more than 18 years of age and of good character, that she has had two years' experience in the care of the sick and is qualified to practice as a trained attendant. Such candidates must also be certified to by three licensed physicians who have personal knowledge of the applicant's qualifications. Finally, there is a saving clause, which states that nothing contained in the bill shall prevent any person from engaging in nursing, provided that he or she does not assume the title of trained, certified, graduate or registered nurse or trained attendant.

SUPERVITAMINS

This from a recent issue of *Physiological Abstracts:*

Three dogs fed on the same diet with the addition of 2 to 3 per cent. "Orypan," a commercial vitamine, lived for 3 to 6 months and retained their desire for food for a much longer period.

With the present high cost of foodstuffs, one may question the wisdom of taking anything that will prolong the desire for food after death. Nevertheless, this chemico-physiologic achievement evokes one's admiration. Science is, indeed, wonderful.

Hematogenous Peritonitis.—Of the various germs which apparently obtain entrance by the blood stream and produce a generalized peritonitis, the pneumococcus is the best known. There is a strong probability that this germ can enter the peritoneum by passing inward along the fallopian tubes without producing any inflammatory reaction in the tubes.—W. H. Battle, *Clin. Jour.*, October, 1919.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

CALIFORNIA

Illegal Practitioner Fined.—Shew Ping, a Chinese herb doctor of San Francisco, was found guilty of practicing medicine without a license and was fined $200.

Chiropractic Act on Ballot.—An act providing for the creation of a board of chiropractic examiners apart from the state board of medical examiners will be on the 1920 California ballot.

ILLINOIS

Society Organ Resumes Publication.—The *Bulletin*, a monthly publication, the official organ of the Montgomery County Medical Society, which was suspended during the war, resumed publication with the November issue.

Physician Acquitted.—In the case of Dr. Horace Reddish, Jerseyville, charged with the murder of his father and a domestic in their home near Jerseyville several months ago, the jury, December 10, found the defendant not guilty.

Indicted as Illegal Practitioners.—According to report, Miss Victoria Japa of 4423 Walton Street, Chicago, was arrested by the department of registration and education for practicing as a midwife without a state license, and was fined $50 and costs.——Andrew Garratt of East St. Louis was arrested for practicing medicine without a license and was fined $50 and costs. He could not pay the fine and was committed to the county jail for two months.——Carl E. Schulte of St. Louis was also arrested by the department for practicing medicine in Illinois without a state license. Schulte was fined $50 and costs, the total amount being $83.40, which he paid.

Chiropractors Fined.—For the third time in eighteen months Mrs. Emma Calvin of Monticello has been fined for practicing as a chiropractor without a state license. The fine in each of the former convictions was $150 and costs, and for the third conviction the fine is $200 and costs and ten days in jail. This is said to be the first jail sentence the Illinois Department of Registration and Education has been able to secure against a chiropractor for practicing without a state license. Mrs. Calvin graduated from the Palmer School of Chiropractic at Davenport, Iowa, and claims that by reason of such graduation she is entitled to treat human ailments without regard to any law on the subject.——H. N. Mettler of Rock Island, another chiropractor, has been fined $200 and costs for practicing without a state license. Mettler is also a Palmer graduate and, like all other chiropractors who are not licensed, claims that the law does not apply to him. On a former occasion, Mettler was fined $150 for violating the medical practice act, paid the fine, and started right to practicing again.

Chicago

College of Surgeons Secures Home.—The Nickerson residence on East Erie Street has been purchased by the Chicago members of the American College of Surgeons and turned over to that organization to be used as an administrative home.

More Money Asked for Speedway.—In order to complete the Speedway Hospital it will be necessary to ask Congress to appropriate at least $2,500,000, bringing the cost of the project up to $5,500,000. The Surgeon-General, U. S. P. H. S., is reported to favor the project.

Washingtonian Home Closed.—The Washingtonian Home, which has been in existence for more than half a century and is said to have a record of 50,000 cures, will close its doors, January 1, on account of the decrease in patronage from 100 patients a month to twelve or fifteen. It is expected that the energies of the organization will be devoted to the treatment of drug addicts.

Grant for Medical Research.—At the annual meeting of the Committee for Grants for Research of the American Association for the Advancement of Science, the sum of $400 was awarded to Leslie B. Arey, Ph.D., of Northwestern University Medical School in support of his study of the origin, growth and fate of giant cells or osteoclasts which have usually been held responsible for bone dissolution.

Former Assistants Honor Professor LeCount.—December 17, former assistants of Dr. Edwin R. Le Count, professor of pathology in Rush Medical College, tendered him a banquet and presented him with two paintings as a recognition of esteem and gratitude. The presentation address was made by D.: Frank R. Nuzum, Janesville, Wis., who presided. Addresses were also made by Drs. Herman A. Brennecke, Aurora; George E. Clements, Crawfordsville, Ind.; William H. Burmeister, George H. Coleman, Arthur H. Curtis, Morris Fishbein, Edward H. Hatton and James P. Simonds, Chicago.

Physician Convicted.—Dr. Lillian Hobbs Seymour, also known as Dr. Lillian R. Hobbs, is said to have been convicted of murder by abortion, December 16, by a jury in Judge Scanlon's court and to have been sentenced to imprisonment for fourteen years in the state penitentiary. This is the second time Dr. Hobbs was placed on trial in the same case. In 1916, she was found guilty and sentenced to fourteen years imprisonment, but later was granted a new hearing on technicality. The conviction is said to have been based on antimortem statements of the two young women on whom she is said to have performed an illegal operation.

INDIANA

Personal.—Dr. Augustus R. Schaefer, Alexandria, was found insensible and almost frozen at his home, December 10, and is under treatment in the Alexandria Hospital.——Dr. Benoni S. Rose, Evansville, was elected president and Dr. J. S. Stephens, secretary, of the Medical Service Club of Evansville.——Dr. Milton C. Wilson, Lafayette, has been appointed physician for the county farm and county jail.——Dr. William C. Dunscombe, Lafayette, has resigned as superintendent of the Wabash Valley Sanitarium, Lafayette.——Dr. George S. Bliss, superintendent of the Indiana School for Feeble-Minded Youth, Fort Wayne, has resigned.

MARYLAND

National Guard Item.—The Adjutant-General of Maryland has been authorized by the War Department to organize a field hospital company (motorized) for the national guard of the state.

Libraries to Be United.—According to plans now being considered by the authorities of the Johns Hopkins University, the libraries of the hospital, the school of hygiene, and the medical school ultimately will be collected under one roof in a new library building to be erected in the hospital group.

Health Wardens Named.—In naming the health wardens for Baltimore city, Health Commissioner C. Hampson Jones made but five changes among the twenty-eight wardens now connected with the department. Those appointed were: Drs. Maurice Feldman, J. Walker Thomas, Roscoe Z. G. Cross, H. J. Carrick and W. Edward Grempler.

Appointments in Baltimore City Health Department.—Health Commissioner C. Hampson Jones, inaugurating the merit system in the Baltimore City Health Department, has reappointed Dr. John F. Hogan, assistant commissioner of health, in charge of the bureau of communicable diseases, and Dr. Marion B. Hopkins, chief of the bureau of food and dairy inspection.

Joint Meeting.—A joint meeting of the Maryland Psychiatric Society, Baltimore County Medical Association and State Lunacy Commission, to which the members of both the State and Baltimore City Bar Association were invited, was held December 17, at the Spring Grove State Hospital at Catonsville, to discuss the question of the care of the criminal insane. Addresses were made by Dr. A. P. Herring, secretary of the Lunacy Commission, and by Dr. John Oliver. Plans to be laid before the legislature for 1920 were considered.

Appointments to Baltimore Health Department.—Giving further evidence of his intention to put the health department on an efficiency basis, Dr. C. Hampson Jones, health commissioner, has reappointed the following: Dr. William Royal Stokes, chief bacteriologist; Dr. Mary Sherwood, head of the bureau for the prevention of infant mortality; Dr. Mary C. Willis, assistant to Dr. Sherwood; Dr. C. L. Ewing, assistant bacteriologist, and Dr. John E. O'Neill, superintendent of the tuberculosis dispensary. In addition he has appointed: Dr. Howard J Maldeis, city medical examiner; Dr. Standish McCleary, assistant medical examiner, and Dr. Bartus T. Baggott, assistant physician in the tuberculosis dispensary.

MISSOURI

Bill for New Marine Hospital in St. Louis.—Congressman L. C. Dyer of Missouri has introduced a bill (H. R. 11,333) in the House of Representatives authorizing the Secretary of the Treasury to sell the present marine hospital site and to acquire a suitable and sufficient site in or near St. Louis for the construction of "a complete hospital plant for the treatment of beneficiaries of the War Risk Insurance and Public Health Service." It was referred to the House Committee on Buildings and Grounds.

NEBRASKA

Personal.—Dr. Ira H. Dillon, Auburn, has been appointed chief of the bureau of public health of Lincoln.——Dr. Alfred E. Westervelt, Omaha, is in Manchuria working against cholera under the central division of the Red Cross.——Dr. David G. Griffiths, formerly superintendent of the Beatrice Hospital for the Feeble-Minded, has been appointed superintendent of the Lincoln State Hospital for the Insane and has been succeeded at Beatrice by Dr. Samuel J. Stewart, Hastings.——Dr. Philip H. Bartholomew, Blue Hill, has been succeeded by Dr. Richard T. Leeder as representative of the government in the office of the state board of health.

NORTH CAROLINA

Personal.—Dr. Joseph A. Speed has been appointed college physician of Trinity College, Durham.——Dr. Harry Q. Alexander, Pineville, has resigned as president of the North Carolina Farmer's Union, and will resume practice.

New Sanatorium.—Dr. Watson S. Rankin, Raleigh; Richard M. King, James E. Smoot, Joe A. Hartsell, William D. Pemberton and William H. Wadsworth, all of Concord, have purchased the Wagoner Grove and will erect on this site a hospital, to be known as the Cabarrus Sanatorium, at a cost of about $60,000.

Plans for Health Work.—Dr. Watson S. Rankin, secretary of the state board of health, Raleigh, November 22, held a conference with Drs. E. F. Long, Davidson County; A. C. Bulla, Forsyth County, and J. L. Smith, Wilson County, in order to map out plans for the fifteen cooperating counties of the state for health work during the next year.

New Officers.—Guilford County Medical Society, at its annual meeting held in Greensboro, December 4, elected Dr. Charles W. Banner, president; Dr. Robert A. Schoonover, vice president, and Dr. Frederick J. Pate, secretary-treasurer, all of Greensboro.——Physicians of the Tenth Congressional District met in Asheville, November 12, and organized the Tenth District Medical Society. The following officers were elected: president, Dr. Clyde E. Cotton, Asheville; vice presidents, Drs. John R. McCracken, Waynesville, Maywood County; Percival R. Bennett, Bryson City, Swain County; Fred L. Siler, Franklin, Macon County, and Benjamin L. Ashworth, Marion, McDowell County, and secretary, Dr. William J. Hunnicutt, Asheville.

PENNSYLVANIA

Gorgas in Pittsburgh.—January 8, Gen. William C. Gorgas, formerly Surgeon-General, U. S. Army, will deliver an address on "Yellow Fever," in Pittsburgh, under the auspices of the Society for Biological Research of the University of Pittsburgh.

Field Hospital and Ambulance Companies Authorised.—The Adjutant-General of Pennsylvania has been authorized by the War Department to organize four field hospitals (motorized) and one headquarters, and four ambulances (motorized) and one headquarters for the national guard of the state.

First Social Disease in Quarantine in Pennsylvania.—The first quarantine for social disease in Pennsylvania was enforced by the Harrisburg department of health and the state health department The victim, after being warned, broke quarantine and was arrested and sent to jail and her cell quarantined. State and city health authorities visited the house and placed a big yellow placard on the door with the name of the disease prominently displayed as a warning to the public. The same regulations apply to the quarantine as in smallpox. The woman left the house less than two hours after the quarantine was established.

Philadelphia

Gift to Hospital.—Seven acres adjoining the Chestnut Hill Hospital have been presented to the institution by Henry A.

Laughlan of Chestnut Hill. Mr. Laughlan made the donation in memory of his wife, Mary Reed Laughlan. Through this gift it is possible for the hospital to continue on its present site; if necessary, funds can be raised to make contemplated improvements, and the hospital will meet the demands of Chestnut Hill residents for additional accommodations. Henry Wharton and Joseph C. Fraley have each pledged $1,000 toward the new project.

Army Equipment for Hospital.—Improvements and equipment valued at nearly $75,000 have been offered to the Philadelphia General Hospital by the United States Army which used part of the institution as a base hospital during the last year. The army authorities had a contract with the city by which they got the use of part of the hospital at a rental of $1 a year on condition that when they left the institution they would put it in its original condition. Thousands of dollars were spent in painting and renovating the wards, putting in a modern kitchen, improving plumbing and adding to the equipment which the city had on hand at the institution, and the "putting back in original condition" by the army would have meant the destruction of most of these improvements, according to Director Krusen of the Department of Public Health and Charities. In addition the city was able to buy for $250 a Red Cross building, erected by the War Department at many times that cost. This is expected to be one of the most useful additions to the city's hospital.

Personal.—Dr. J. A. Lichty, Pittsburgh, delivered an address on "The Treatment of Thyroid and Other Endocrine Disturbances as Viewed by an Internist," before the section on general medicine at the College of Physicians, December 15.——Dr. H. Barr Engle has been elected medical director of the Charity Hospital succeeding Dr. W. Krusen, resigned. ——Dr. Harvey Cushing delivered the second of the series of the Nathan Lewis Hatfield lectures at the College of Physicians, December 16. His subject was "The Major Trigeminal Neuralgias and Their Surgical Treatment."——Dr. George M. Kober of Washington delivered a lecture on "Occupation in Relation to Tuberculosis," before the section of industrial medicine and public health of the College of Physicians, December 17.——Dr. Wilmer Krusen will be the guest of honor at a testimonial dinner given by the physicians of Philadelphia at the Bellevue-Stratford Hotel, December 30.——Dr. C. Lincoln Furbush, incoming director of Public Health of Philadelphia, will be the guest of honor at a reception held in the Hotel Adelphia, January 9, and given by the Northern Medical Association to celebrate its seventy-fourth anniversary.——Dr. S. S. Woody of the Philadelphia Hospital for Contagious Diseases, has just returned from Georgetown, Del., where he went at the request of that state to aid in the fight against smallpox. According to Dr. Woody, the cases at Georgetown, while many, are very mild and the local medical authorities have the matter well in hand. General vaccination has been ordered and preparations for emergency hospitals should necessity require. ——Dr. R. C. Rosenberger has been appointed director and clinical pathologist of the new pathologic laboratory of the Philadelphia General Hospital by Dr. Wilmer Krusen of the Department of Public Health and Charities.

SOUTH CAROLINA

Hospital Note.—Hopewell Sanatorium, Greenville, plans to erect a separate ward for negro patients to cost $6,000. Of this amount Greenville County has provided $2,500.

SOUTH DAKOTA

District Officers Elected.—At the annual meeting of the Sioux Falls District Medical Society, December 2, at Sioux Falls, Dr. Guy E. Van Demark was elected president; Dr. Edmund D. Putnam, vice president, and Dr. Samuel A. Keller, secretary-treasurer, all of Sioux Falls.

Personal.—Dr. John W. Freeman, Lead, and Robert D. Alway, Aberdeen, have been appointed members of the state board of medical examiners.——Dr. Goldie E. Zimmerman, Sioux Falls, has been appointed health examiner for young women at the Northern Normal and Industrial School, Aberdeen.

TENNESSEE

Branch Laboratory Established.—The first branch laboratory of the state board of health has begun work in West Tennessee. This work has been undertaken by the University of Tennessee Medical School, and will be carried on by the laboratories of the departments of bacteriology and public health at the University.

Hospital Notes.—Drs. Charles P. Edwards and Enoch W. Tipton have purchased from the city of Kingsport the Community Hospital which was founded in 1918 for checking influenza.——Announcement is made that Vanderbilt University has taken over the Galloway Memorial Hospital, Nashville, and will immediately complete it and put it in operation.

Vanderbilt Gets Four Million Dollars.—It has just been announced that the General Education Board, New York, has appropriated $4,000,000 to enable Vanderbilt University, Nashville, to reorganize completely its medical school. This amount is said to come from the general funds of the board and not out of Mr. Rockefeller's recent donation of $20,000,000 for the promotion of medical education in the United States.

Harrison Law Violator Sentenced.—In the case of Dr. Ben Freidman, Memphis, who is said to have been convicted of violating the Harrison Narcotic Law, and who appealed to the district court of appeals and then to the Supreme Court of the United States, the decision of the lower courts has been sustained and the defendant, who had been sentenced to imprisonment for two years in the federal penitentiary, Atlanta, was taken to Atlanta, December 6, to begin his term.

Personal.—Dr. Walter S. Nash has been appointed chief of the medical staff of the Knoxville City Hospital.——Dr. Clarence B. A. Turner, Newbern, has been appointed president of the Dyer County Board of Health, succeeding Dr. Stanley B. Sharpe, Dyersburg, resigned.——Dr. Iverson L. Lofton, Nashville, is reported to be seriously ill as the result of a cerebral hemorrhage.——Drs. Worcester A. Bryan, Lucius E. Burch, and Robert W. Grizzard, Jr., have been elected as the executive committee of the medical staff of the Woman's Hospital, Nashville.——Dr. Herbert L. Baugh, Flynnslick, has been appointed registrar of vital statistics for the state board of health.

TEXAS

Convalescent Home Burns.—The Red Cross Convalescent Home, Fort Bliss, in which about fifty returned soldiers were being cared for, was destroyed by fire, December 6. All the patients were removed in safety.

Health Department Plan Adopted.—The county health department plan has been inaugurated in Wichita and Bell counties, and will be inaugurated in Wilson, Tarrant, and Jefferson counties by January 1.

Memorial Hospital for Cooper.—A movement has taken tangible form to build at Cooper a hospital to cost not less than $50,000 as a memorial to the soldiers from Delta County who fell in the world war.

Clinics at Dallas Hospitals.—Medical clinics were held in Dallas, November 24 and 25, by Drs. Llewellys F. Barker, Baltimore; Joseph C. Bloodgood, Baltimore; George W. Crile, Cleveland, and Drs. Rudolph Matas and Isadore Dyer, New Orleans. The clinics were held at the St. Paul and Baptist sanatoriums, and the City Hospital.

Personal.—Dr. Beverly T. Young, San Antonio, superintendent of the Southwestern Insane Asylum for several years, has resigned and has been succeeded by Dr. Job G. Springer, Elmendorf.——Dr. Lane B. Kline has resigned as city health officer of Houston, and has been succeeded temporarily by Dr. Carl B. Young.——Dr. Gustavus A. Spivey has been appointed assistant health officer of Dallas County and has resigned as a member of the staff of the Emergency Hospital, Dallas.

CANADA

Personal.—Dr. Neil Macphater, Calgary, Alta., was operated on recently at the Presbyterian Hospital, Chicago, for glaucoma of the right eye, and is reported to be doing well.

Hospital News.—The N. C. O's and men of No. 3 Canadian General Hospital (McGill University) have taken steps to form a permanent club to be composed solely of members of the unit. Brig.-Gen. H. S. Birkett, C.B., commander of the hospital in France in 1915, presided at the initial meeting. ——The hospital at Summerland, B. C., was destroyed by fire on Dec. 16, 1919. The patients and staff escaped uninjured. The loss totals $12,000.

Medical Societies.—At its recent annual convention, the Manitoba Medical Association elected the following officers:

president, Col. John A. Gunn, M.D., Winnipeg; secretary, Dr. Thomas K. G. Hamilton, Winnipeg; treasurer, Dr. Sidney J. S. Peirce, Brandon.——The Alberta Medical Association has elected the following officers: president, Dr. William F. Gershaw, Medicine Hat, and vice presidents, Drs. Walter S. Galbraith, Lethbridge, and Robert B. Wells, Edmonton.

Public Health News.—The Toronto city council having refused to issue a proclamation putting the Ontario Vaccination Act into effect as regards compulsory vaccination in that city, the provincial board of health has taken up the matter, and an order of the court is being sought to compel the city of Toronto to do its duty. The case comes up for hearing on December 23. In the meantime smallpox continues to spread in Toronto, and the total number of cases to date is more than 1,600. So far there have been no deaths. ——All Ontario is now in quarantine so far as Montreal is concerned. No person traveling from the province of Ontario into Montreal, nor any citizen of the United States entering Montreal via Ontario, will be permitted entrance into that city unless able to produce certificate of vaccination within seven years. Failing such, or immediate vaccination by vaccinators on the trains, they must return to their homes.

University News.—Extension courses and lectures for graduates in medicine are being established for the practitioners of the province of Ontario by the Medical Faculty of the University of Toronto. A standing committee has been appointed to advise as to clinics and lectures. The committee will be prepared to arrange lectures to aid medical societies or groups of physicians who desire to keep up to date.——Talk has been revived concerning the removal of Queens medical faculty from Kingston to Ottawa. Members of the board of trade of Kingston and citizens recently discussed it at a largely attended meeting of that body and a resolution unanimously passed that every effort should be made to retain the medical faculty in Kingston. Principal Taylor said that if the entire medical college was to be kept in Kingston, $1,000,000 would be needed, while if part of it were moved to Ottawa, one or two chairs would have to be duplicated. Pressure to make the move had come from the graduates of Queen's and Principal Taylor said it was not to be lightly regarded.

GENERAL

Society Changes Name.—The Western Roentgen Society at its recent meeting in Chicago changed its name to the Radiological Society of North America.

Industrial Nursing.—The industrial nurses of the National Organization for Public Health Nursing plan to form an industrial nursing section in the National Organization at the meeting in Atlanta, Ga., next April. The object of this section will be the formation and maintenance of high standards for service in industry.

Hygiene and Prohibition Help Health.—Surgeon-General Rupert Blue states that the improvement of the health conditions in the United States during the last year has been due partly to prohibition and partly to the lessons of hygiene learned in the war. The relief from war strain also was a factor in the reduction of illness.

Bequests and Donations.—The following bequests and donations have recently been announced:

Mount Sinai Hospital, Chicago, $4,000, the proceeds of a musical pageant given in Chicago, December 7.

Children's Hospital, Boston, and Convalescent Home of the Children's Hospital, Boston, each $10,000; Baldwinville (Mass.) Cottage Hospital for Children, $5,000, by the will of Caroline S. Freeman, Weston, Mass.

Passavant Memorial Hospital, Chicago, $100,000, the proceeds of the Atlantic City Board Walk, the second week in December.

Bill for Examination by Physicians of Pension Bureau.—A bill to empower examining surgeons now employed by the Pension Bureau to make medical examinations for the War Risk Insurance Bureau and Federal Board of Vocation Education has been introduced in the House by Congressman Louis C. Crampton of Michigan. It is understood that the measure contemplates economy and the reduction of duplication of effort in performing examinations. The measure has been referred to the House Committee on Interstate and Foreign Commerce. It is H. R. 10,972.

Sioux Valley Physicians to Meet.—Sioux Valley Medical Association will hold its twenty-fourth semiannual session at Sioux City, Iowa, January 21 and 22, with headquarters at Hotel Martin, under the presidency of Dr. Alfred E. Spalding, Luverne, Minn. The banquet will be held on the evening of the first day at which Col. Robert M. Culler, M. C., U. S. Army, will deliver an address on "Medical Memories of the War," and Dr. Donald Macrae, Jr., Council Bluffs, Iowa, formerly colonel, M. C., U S. Army, will speak on "Who Won the War."

Personal.—George A. Lung, Captain, M. C., U. S. Navy, who has been for a long time in command of the U. S. Naval Hospital, Brooklyn, and has recently been transferred to the command of the Naval Hospital, Newport News, Va., was given a farewell dinner and theater party, December 8. After the theater, Captain Lung was the guest of a supper party at Hotel Astor.——Dr. William J. Mayo, Rochester, Minn., and Dr. Franklin H. Martin, Chicago, will leave for the Argentine Republic and other South American countries, January 7.——Dr. Robert H. Crawford, Rock Hill, S. C., has been awarded the Greek Medal of Military Merit.

Seaboard Physicians Hold Meeting.—The twenty-fourth annual meeting of the Seaboard Medical Association of Virginia and North Carolina was held in Norfolk, Va., December 2 to 4, under the presidency of Dr. William L. Harris, Norfolk. Elizabeth City, N. C., was selected as the next place of meeting, and the following officers were elected: president, Dr. Cyrus Thompson, Jacksonville, N. C., vice presidents, Drs. Edward C. S. Taliaferro, Norfolk, Va.; Zenas Fearing, Elizabeth City, N. C.; Thomas B. Luxford, Princess Anne, Va., and Stuart M. Mann, Moyock, N. C.; secretary, Dr. Clarence Porter Jones, Newport News, Va., and treasurer, Dr. George A. Caton, Newbern, N. C.

Deficiency Appropriation for Public Health Service.—Both branches of Congress have passed an urgent deficiency appropriation measure which carries the sum of $2,000,000 to be expended by the United States Public Health Service. This amount is to be expended "for medical, surgical, and hospital services and supplies for war risk insurance patients and other beneficiaries of the Public Health Service, including necessary personnel, regular and reserve commissioned officers of the Public Health Service, clerical help in the District of Columbia and elsewhere, maintenance, equipment, leases, fuel, lights, water, printing, freight, transportation, and travel, maintenance and operation of passenger motor vehicles, and reasonable burial expenses." The measure also provides for the completion of the government hospital at Broadview, Cook County, Illinois, and authorizes the Secretary of the Treasury to submit additional estimates up to $2,500,000 for making it a "complete working hospital." The measure has gone to the President for approval.

FOREIGN

Honor to British Admiral.—Surgeon Vice-Admiral Sir Robert Hill, medical director general of the Royal Navy, has been awarded, in the name of the U. S. Navy, the Distinguished Service Medal.

Prize Offered for Cure of Foot-and-Mouth Disease.—The *Policlinico* states that the Federation of Dairies in the Cremona district has offered a prize of 100,000 lire for any means that will arrest the damage wrought by epizootic foot-and-mouth disease.

Prize to Swedish Physiologist.—The Swedish Medical Association has awarded its jubilee prize this year to Dr. Hans Gertz of the physiology laboratory of the Karolinska Institut for his work on the functions of the labyrinth. It was published in the *Nordisk Medicinskt Arkiv* in 1918.

From Palace to Hospital.—The Charlottenburg royal residence at Berlin has been transformed into a large hospital and vocational school for the wounded soldiers. Barracks have been erected in the grounds to supplement the buildings, and provide workrooms for making artificial limbs, etc.

New Quarantine Hospital at Newchwang, China.—A new quarantine hospital is being built at Newchwang under the auspices of the Manchurian Plague Prevention Service at a cost of 40,000 taels, the money to be drawn from the local customs. Dr. Wu Lien-teh, president of the National Medical Association of China and editor of the *National Medical Journal* of China, has been appointed to have charge of this hospital.

Chinese Physician Goes to Johns Hopkins School of Hygiene and Public Health.—Dr. Lim Chong Eang, M.B., B.S. (Hongkong), for the past two years senior medical officer of the Peking Central Hospital, has obtained a Rockefeller fellowship and will proceed to Johns Hopkins University to enter the School of Hygiene and Public

Health, where he expects to work for his P.H.D. (doctor of public health) degree.

Chinese Students in America.—According to the Chinese students' directory published by the Chinese Students' Alliance of America, there are 1,124 Chinese students now studying in various colleges in the United States. Of chiefly professional studies, medicine comes first with fifty-eight students; mechanical engineering is a close second, with fifty-seven students; pharmacy claims eleven students, dentistry nine, bacteriology three and sanitary engineering two.

Professor Murri's Gift to Hospital.—Prof. Augusto Murri of the chair of clinical medicine at the University of Bologna some years ago presented the children's seaside sanatorium of the district with 200,000 lire, and he has recently given the sanatorium another 200,000 lire. In his gift letter he remarks that although these sums are not large they represent sixty-six years of professional work in the Bologna district, as he had no inherited fortune. The authorities have decided to call the sanatorium in future the Augusto Murri Ospizio Marino.

Medical School Construction in China.—The Rockefeller Foundation has delayed work on the medical school which is to be built at Shanghai until the completion of the Peking Union Medical College. The increased cost of labor and materials has made it necessary to increase the estimated cost at Peking to $5,000,000. Work is being pushed vigorously, the faculty at Peking college is being recruited and contributions toward the maintenance of various mission hospitals are being made. The China Medical Board expended $2,131,588 in 1918, including $1,619,666 for the land, buildings and equipment of Peking Union College, and $51,575 for scholarships.

The Medical History of the War in Italy.—The military authorities in Italy are compiling records and collecting data for the museum connected with the Scuola di applicazione di Sanità militare: specimens, photographs, radiograms, projectiles extracted, plastic models of wounded regions and of mutilations from wounds and freezing, prostheses, photographs of surgical stations in different zones of the country, of medical officers and other data on war surgery, epidemiology and prophylaxis of infectious diseases, etc. All the medical officers have been asked for contributions of this kind for the museum to make it a comprehensive historical and scientific record of the world war.

Italian Internal Medicine Society.—The annual meeting of the Società italiana di Medicina interna was held in October at Trieste. The subjects discussed were mainly the acquisitions during the war in our knowledge of disease of the nervous system, heart and kidneys, and of typhoid, spirochetosis, malaria, etc. The presiding officers for the coming year are Professor and Senator E. Maragliano of Genoa, Prof. V. Ascoli of Rome and Prof. L. Lucatello of Padua, director of the *Gazzetta degli Ospedali*, with Dr. G. Galli as treasurer. Professor Ascoli is chairman of the committee of organization for the next meeting to be held at Rome. The subjects appointed for discussion are bronchial asthma and lymphogranulomatosis.

Anniversary Celebration of the Milan Instituto Sieroterapico.—The *Policlinico* relates that the twenty-fifth anniversary of the foundation of this well known institution at Milan was recently celebrated with much ceremony. Among those who have contributed most to its success are Professors Negri, Menozzi, Nicolai and the senator professors Mangiagalli and Golgi. Prof. Tito Carbone succumbed some years ago to laboratory infection contracted in the service. The institution is now in charge of Professor Belfanti, and Senator Golgi presented him with a bronze tablet and announced increased pay for the personnel. At the same time an oil portrait of Golgi was presented. The ceremonies concluded with a banquet to the 300 persons connected with the institution.

Honors for Professor Pitres.—The French government some time ago conferred the title of commander of the Legion of Honor on the professor of clinical medicine and dean of the University of Bordeaux, Dr. J. A. Pitres. This is an honor rarely conferred on physicians, and his friends arranged a formal celebration of the occasion recently, presenting him also with a portrait medallion. His name is well known around the world by his *signe du sou* and other signs, his work on neurology, on the changes in the shape of the heart from staying long in bed, on the phlebosclerosis of malaria, etc. To his initiative is due the degree of "colonial physician" now conferred by the university, and the foundation of the museum of ethnography and colonial research. As he has reached the age limit, this is his last term as acting professor.

Foundation of Swedish Association for Medical Research.—On the initiative of Professors Forssner, Forssell, Holmgren and Dr. Key of Stockholm, and Professors Quensel and Petrén of Upsala and Lund, a meeting was held recently to organize the Svenska Sällskapet for medicinsk forskning to promote scientific research in Sweden. Already 169 members are enrolled and the officers elected. They include a number of prominent laymen, directors of banks, consuls and others besides leading professors in the medical sciences. Professor Quensel in the opening address emphasized that the rapidly changing world has brought the necessity for new orientations and the blocking out of new routes, and he cited the saying, "If the human race can be perfected, it is in the medical sciences that the means for this must be sought." The aim of the new society is to provide funds for medical research, and the treasury starts with a donation of 5,000 crowns from a legacy. Full details of the organization are given in *Hygiea* for October 31, p. 833.

Status of Public Health in Hongkong.—Although Hongkong has made wonderful strides in an economic way under the guidance of the British Empire, the same success has not been achieved in public health matters, according to the *National Medical Journal*, September, 1919. Epidemics of smallpox and bubonic plague occur almost yearly. Tuberculosis reigns unchecked. There is still no hospital worthy of the name where the Chinese could see with their own eyes the great advances which modern medicine has made during the past decade. The Tung Wa Hospital is still run on primitive lines. Under so-called "native" treatment, the mortality, as shown in the medical and sanitary reports for 1918 issued by the British colony of Hongkong, was 35.9 per cent., whereas under "western" treatment, the mortality was only 17.1 per cent. It is suggested that if the Cantonese could be given the example of an efficiently managed modern hospital to which the Hongkong University could send its medical students, the prejudices of the Cantonese would disappear.

LATIN AMERICA

Medical Students in Chile.—During the year of 1918 there were in the medical school of Chile 948 students, fifty-eight of whom were women. There were 233 students studying pharmacy.

New Quarantine Station in Peru.—There was established recently in Peru the quarantine station of San Lorenzo at which first and second class passengers will be isolated when suspected of having diseases that may threaten the public health.

Railroad Hospitals in Mexico.—The railroad medical department of Mexico has at present seventeen railroad hospitals located at strategic points and provided with the necessary equipment. During the year September, 1918, to August, 1919, there were treated 2,217 hospital patients and 4,983 outpatients.

Memorial to Dr. Hernandez.—As a memorial to Dr. José Gregorio Hernandez, a prominent physician who died recently at Caracas, Venezuela, the Students' Scientific Center has just created for indigent patients a clinic which will be named after him and will be connected with the society Amparo Infantil.

Monument to Dr. Finlay.—Among recent appropriations made in Cuba there is one providing $225,000 to remodel the Hospital Las Animas of Havana and erect a monument to Dr. Carlos Finlay at the entrance of the hospital. Other appropriations provided $380,000 for three years in succession for sanitary improvements in the city of Guantanamo; $85,000 to drain the lands that surround the town of Caimanera; $135,000 for the construction at the national university of a building for the school of pharmacy, and installing a department devoted to teaching the manufacture of serums and vaccines; and $24,000 and $60,000 for the construction of hospitals in the cities of Nuevitas and Jiguani, respectively.

CORRECTION

"Differential Diagnosis of Hyperthyroidism."—In the abstract of Dr. G. W. McCaskey's article on this subject which appeared in THE JOURNAL, Dec. 13, 1919, p. 1855, the line next to the last should read "below 140 mg. of sugar in 100 c.c. of blood," etc., instead of 1,000 c.c.

Government Services

Personnel of the Medical Department

For the week ending December 19, there were on duty in the medical department 2,212 medical officers, including 1 major-general, 2 brigadier-generals, 163 colonels, 152 lieutenant-colonels, 528 majors, 836 captains and 520 first lieutenants. The medical reserve corps contained 4,183 officers, an increase of 74 from the previous week, which included 2 brigadier-generals, 74 colonels, 254 lieutenant-colonels, 1,125 majors, 1,753 captains and 890 first lieutenants.

MEDICAL OFFICERS, U. S. NAVY, RELIEVED FROM ACTIVE DUTY

ARKANSAS
Nashville—Nelson, C. H.

CALIFORNIA
San Francisco—Winnard, W. F. R.

MASSACHUSETTS
Brookline—Wilcox, J. M.

MISSISSIPPI
Raymond—Hagaman, F. H.

OREGON
Grant's Pass—Johnson, J. P. M.

PENNSYLVANIA
Coudersport—Smith, J. H.

Report of the Surgeon-General, U. S. Navy

The annual report of the Surgeon-General of the Navy for the fiscal year 1919 reveals the efficiency which has always been characteristic of the Navy. The report includes health statistics up to the close of the calendar year 1918, and operations of the Medical Department of the Navy to June 30, 1919, practically completing the record for war work, except as regards the return of the Army sick and wounded from abroad, and the efforts for the reeducation and rehabilitation of the disabled of the Navy and Marine corps.

The main concern of the Bureau of Medicine and Surgery has continued to be the health of the Navy and of the millions of soldiers committed to its care on the Atlantic in home and foreign waters.

The transportation of Army troops to and from Europe by the Navy and the return of the sick and wounded stand out among the most brilliant achievements of the war. This work was conducted by vessels constituting an integral part of the Navy, the cruiser and transport service and the Army transport service. The number of sick and wounded to be returned was far too great to be carried by the naval hospital ships, and therefore an arrangement developed by which Navy transports on the westward passage would serve to the limit of capacity for the return of Army sick and wounded, and this plan was worked out with great credit to the service. Before the armistice was signed, about 100 Army patients were returned home on each return voyage, as this was all that could be evacuated quickly and safely in case of accident. After the removal of the submarine menace, about 650 patients were carried on each voyage, and this required new organization and an increase in the hospital corps complement. During the fiscal year 1919, seventy-six hospital corps men were received and given instruction in laboratory work before assignment to duty.

The transportation of sick and wounded after the signing of the armistice necessitated an increase in the transport service from thirty-eight to 129 vessels. Many of these ships were provided with adequate sick bays for healthy troops, but not infrequently sick and wounded were sent on these troop ships. It was therefore necessary to maintain on board each vessel a medical department adequate to meet exceptional demands, and for this purpose there was a commissioned medical personnel of more than 500 men. Between Nov. 11, 1918, and June 30, 1919, 1,235,933 troops had been returned by this service from Europe, and of this number 11,522 were classified as sick or wounded.

July 1, 1919, the total of the Medical Corps on active duty numbered 592 officers of the reserve forces, 865 officers of the permanent medical corps, 315 officers holding temporary appointments, and eighty-two former pharmacists commissioned as assistant surgeons. At present there are 301 vacancies in the Medical Corps of the regular establishment. As 104 resignations have been received up to date from officers holding permanent commissions, the size of the vacancy list is giving the bureau considerable concern. It is recommended that Congress provide means whereby officers holding temporary appointments in the Officers Reserve Corps may enter the permanent corps, and that in view of this fact the present statutory age limit be waived and one of 40 years substituted. This will insure to the government twenty-four years of prospective service before retirement on account of age would become operative.

Much thought has been devoted to the provision of an educational program in the specialties for officers of the regular establishment, and it is suggested that a course be mapped out at the United States Naval Medical School which will extend for a period of about three months, during which each officer will be carefully observed to determine his especial fitness. It would then be desirable to arrange special courses in one of the larger medical centers. After such courses, these young officers would be available for assignment as specialists in the naval hospitals, in addition to their duties as general medical officers.

The assignment of female nurses to ships, a practice that was inaugurated during the war, has proved satisfactory; and the character of the professional work, the manner and bearing and general adaptability of the nurses have been most favorable, and the influence has been good. The interests and efficiency of the nurses assigned to the Philippine Islands, Guam, Samoa and Haiti in the developing training schools in their own work, and also the development of training schools for native women, is most praiseworthy.

Many hospital men served independently of medical officers on transport service ships, destroyers and other vessels, and acquitted themselves most creditably. For the training of hospital corps men the medical department maintains one training school at Newport, R. I., one at Great Lakes, Ill., and one at San Francisco, with a capacity of 300 each, and an advanced hospital corps school also with a capacity of 300 at the United States Naval Operating Base, Hampton Roads, Va. The difficulty of maintaining a sufficient proportion of hospital corps men is emphasized. If the Navy is recruited to its allotted strength of 191,000 men, or 218,400 including the Marine Corps and Hospital Corps, at least 7,500 men will be required. Since January, 1919, there have been only 493 reenlistments, and of these 400 are eligible for release; and during the same period more than 8,000 men have been discharged

Casualties in the Medical Department on duty with the Marine Corps include one commissioned officer and twelve enlisted men killed, eight commissioned officers and 101 enlisted men wounded or gassed, and one enlisted man taken prisoner.

The medical personnel of the Naval Aviation Forces in Europe consisted of seventy-two medical officers, fifteen dental officers, four pharmacists and 294 enlisted men, and their commander reports most favorably on the professional ability and devotion to duty of these men.

The most general complaint of officers and men on duty on submarines was with reference to the ear, with the syndrome of middle-ear catarrh. A number of cases of eye strain prevailed toward the end of the series of patrols. These were believed to have resulted chiefly from excessive use of the eye, defective lighting, refractive errors, and glare. The majority of the personnel were constipated during the patrol; it was not practicable during the patrol to provide facilities for men to get into open air on deck. Gradual deterioration of officers and men developed as patrols proceeded. This, in general, was not of a serious nature, and in the great majority of cases complete recovery followed.

June 30, 1919, there remained a total of 14,891 available beds under Navy control in hospitals on this continent. During the year the hospitals abroad at Leith, Queenstown, Strathpeffer, London, Gibraltar, Genoa, Lorient, Cardeth, Pauillac, Plymouth and Corfu, and one hospital at Brest, were discontinued.

During the year there were twelve commissioned officers and forty-five enlisted men cited for the Distinguished Service Cross; seven commissioned officers and sixteen enlisted men cited for the Croix de Guerre; nineteen commissioned officers and sixty-three enlisted men were awarded the Croix de Guerre; thirteen commissioned officers and twenty-nine enlisted men were awarded the Distinguished Service Cross; eleven commissioned officers and twenty-two enlisted men were recommended for the Distinguished Service Cross; ten commissioned officers and thirty-three enlisted men were recommended for the Croix de Guerre; one commissioned officer was cited for the Medaille Militaire, and eleven commissioned officers and twenty-four enlisted men were mentioned in general orders.

There were 9,307 deaths in the Navy during 1918. Of these, 5,938 were due to disease, 1,158 to accident and injuries, and 2,211 to casualties in action. The death rate for all causes was 18.47 per thousand, and for disease only, 11.78 per thousand. Of the 5,938 deaths from disease, 5,027 were due to pneumonia in one form or another. Influenza and pneumonia were responsible for 1,158 of these deaths. Could pneumonia have been eliminated this year, the death rate of the Navy from disease would have been only 1.80 per thousand. The value of the report is much enhanced by numerous illustrations, plans and graphic charts.

The problems of demobilization are considered at length. It is believed that this is the time to make a careful study and tabulation of findings in regard to demobilization, so that the essential facts may be on record for use should the contingency of war again confront the country. Plans for demobilization should be incorporated with the legislation enacted at the time of expansion to a war footing, and should be deliberately calculated in advance so as fully to subserve the best interests of the nation. The medical and hospital corps must be the last to demobilize after the war.

The Surgeon-General pays an eloquent tribute to the patriotism of the men who left their civilian employment and professions to enter the Naval Medical Reserve Forces.

Foreign Correspondence

MADRID

Nov. 22, 1919.

The Medical Strike of Jerez de la Frontera

The town of Jerez de la Frontera, which has a world reputation on account of its famous wines, has just witnessed the first general strike of physicians. This strike originated because the municipal authorities, disregarding all statutory provisions and trusting to political influence, failed to keep their pledges, and the salaries due the employees finally amounted to 1,000,000 pesetas (about $200,000). When the physicians became tired of seeing that, in this period of better compensation for labor, they were the only ones who could not bring home the wages they had earned, they unanimously decided to go out on strike. The mayor and the members of the town council were very indignant at this action, their arguments running somewhat as follows: "It is very strange that the physicians should be so rebellious, and especially now, when the town council has just spent several thousand dollars for celebrations and bull fights, thus showing our desire to please the people and attract foreigners. The physicians do not bear in mind the fact that we cannot pay their salaries, since to do so would be to show partiality in their favor; in a place where no one is paid, it is an imposition to ask for money. If we have spent so much for festivals it has been only because the bull fighters and actors would not have come otherwise; but every one understands that if we could have got out of paying them, we would not have paid them either." These reasons did not influence the physicians, who suspended all official relations with the municipal authorities, and who, while continuing their care of the poor, refused to submit any reports, would not sign any official certificates, or attend the municipal dispensaries, and let public opinion and the government decide the matter. At first the local authorities threatened the physicians, at whose head was Dr. Aranda, one of the most prominent surgeons of Andalusia. The physicians proved adamant against all kinds of pressure that was brought to bear on them for over a month. At last the government decided to enforce the law; it dismissed the municipal council and appointed new counselors so as to help solve the situation. The result has been that the physicians will immediately receive one half of the amount due them, and the balance very shortly. This is the first medical strike that ever took place in Spain. It has received support not only in the country in general, but also at the hands of the government.

Medical Syndication

The different questions that have come up because of the strikes have brought to the fore the subject of the medical syndicate or trade union. This subject has been the object of many discussions all over Spain, and especially in Madrid. Many lectures and speeches have been delivered both for and against the creation of a syndicate of physicians. This syndicate would naturally have for its model the workingmen's syndicates, which are responsible for the social revolution which is stirring in Barcelona at present.

In the Colegio Médico (medical guild) several meetings have been held to discuss the subject of syndication, and a program has been prepared. When a syndicate of physicians was first proposed, 500 Madrid physicians endorsed the idea; but after seeing the program, up to November 18, only sixty-seven had signed. It seems that Section 6 of the first article is the part to which many physicians object. It is here provided that the physicians can join the workingmen to achieve some of their ends.

Dr. Medinaveitia, the gastro-enterologist, and considered one of the most advanced leaders of Sapnish anarchism, delivered a lecture a few days ago. After making many radical statements, he attacked medical syndicalism and medical strikes. It is his opinion that physicians should not shirk their duties. In the same place, another physician, the laryngologist, Dr. Hinojar, attacked Dr. Medinaveitia's statements, and advised medical syndicalism.

Dr. Lafora, a neurologist, has published in one of the newspapers an article in favor of medical syndicalism, saying that the time had come for the physician to consider himself just a laborer.

Professor Pittaluga and Dr. Juarros have also delivered speeches favoring syndicalism. The journal *La Medicina Ibera* is advocating it, while the dean of the medical press, *El Siglo Médico*, is against it.

The Medical Meeting at Malaga

A meeting of Andalusian physicians was recently held at Malaga. Physicians from other provinces, including Madrid, also attended. The most characteristic note of the meeting was the protest against politicians and the government. This is explained by the fact that the physicians are losing all hope of improvement, seeing that cabinets succeed each other, and still the municipal physicians are left at the mercy of local authorities without receiving the protection to which they believe themselves entitled. The medical classes now think they have found a remedy for this condition, i. e., in the payment of their salaries by the national government. Lately, however, a new political element in favor of political autonomy is attacking this measure. It is a fact that Spanish physicians have not taken part in politics as physicians but as individuals belonging to different parties. Although they have tried to improve national sanitation so far as they had the power to do so, they have always been handicapped by the indifference and ignorance which the politicians display toward sanitary matters.

Death of Dr. Rodriguez Méndez

Dr. Rodriguez Méndez, former president of the University of Barcelona, and professor of hygiene of the Barcelona School of Medicine, died shortly after receiving news of his retirement because of having reached the retirement age. He was in perfect health before his death, and it is asserted that his death was due to grief over his enforced withdrawal from public life. Dr. Rodriguez Méndez was a scientist whose career was marked by enthusiasm for medical teaching, love for humanity, and healthy patriotism. The bitter struggles that have convulsed Barcelona could not alter his devotion to Spain, or his love for the city of Barcelona, where he fought epidemics and assisted all sanitary improvements with such eagerness and tireless activity that he had no enemies and was admired by all for his achievements.

PARIS

Nov. 20, 1919.

The Parliamentary Elections and Social Hygiene

In the numerous political platforms that have seen the light of day in connection with the election campaign preceding the parliamentary elections, questions pertaining to social hygiene have not occupied, it must be confessed, a very conspicuous place. However, I wish to call attention to a manifesto which emphasized the necessity of improving French birth records both quantitatively and qualitatively and of protecting large-sized families. At the head of the list of candidates who signed this manifesto stood the name of Dr. Pinard, former professor of clinical obstetrics on the Paris Faculty of Medicine. Pinard has been one of the well known promoters of the child welfare movement in France.

The Ligue nationale contre l'alcoolisme, of which Professor Debove, former dean of the Paris Faculty of Medicine, is president, has sent to the various political parties the following declaration:

TO THE FRENCH PEOPLE

France, though victorious, is almost exhausted. There rests, therefore, on us the paramount necessity of recuperating our strength. Our industries that have been destroyed by the invader must be built up again. Our domestic and foreign commercial relations, which are the source of our normal economic life, must be reestablished. By means of industry and thrift our exhausted stocks of merchandise must be replenished. And, what is still more important, we must regain our vital equilibrium after the terrible bleeding to which we have been subjected.

But there can be no industry; there can be no commerce; there can be no toil; there can be no thrift; there can be no health, so long as alcohol shall remain the master of France, ruining production, paralyzing trade, diverting labor from its proper channels, devouring the savings of the people, and generating disease, folly and crime. We are now facing a different kind of a struggle—an enemy so implacable that the British prime minister has publicly announced that a world crisis has been reached which is even more threatening than that imposed by the Germans.

Voters!

The nations round about us, neutrals as well as allies, though not so deeply affected as ourselves, have comprehended the danger. Norway, Sweden and Belgium have imposed on themselves severe restrictions. The United States has prohibited all intoxicating beverages.

Is France alone incapable of renouncing its appetizers and its liqueurs?

Demand of your candidates that they shall take a definite stand as advocates of the immediate prohibition of beverage alcohol or at least declare themselves disposed to prepare the way for such prohibition by voting for: (1) the radical suppression of the privilege of private stills; (2) a marked reduction in the number of places licensed to dispense intoxicating beverages; (3) an increase of the tax on beverage alcohol with a corresponding reduction of the duties on alcohol used in the industries; and (4) denial of wine merchants of a license to conduct a tobacco store in connection with a wine shop.

Refuse to vote for those who give you a negative or evasive answer.

Voters: remember that if France does not suppress alcohol, alcohol will suppress France.

Antituberculosis Propaganda

The various representatives of the societies in the United States, Great Britain and France that are concerned with the world-wide antituberculosis campaign held a meeting here recently under the chairmanship of M. Léon Bourgeois, president of the Comité national de défense contre la tuberculose. It was decided that a conference should be held in Paris next year in October for the purpose of drawing up the constitution of an association to be composed of the delegates of the national antituberculosis societies of the different countries that constitute the league of nations.

A Resolution of the Surgical Congress

The Congrès de chirurgie, at the instance of its president, Dr. Walther, has unanimously adopted the following resolution:

WHEREAS, The Congrès français de chirurgie is fully aware that: (1) the indigent sick in hospitals (formations hospitalières) are entitled to receive such care as will secure to them all the physical guarantees of safety that comport with present medical standards; and (2) a large number of surgical services are still inadequately equipped and lack the indispensable equipment for the examination and treatment of the sick—often even the necessary apparatus for the sterilization of instruments, etc.; therefore, be it

Resolved, That in all these hospitals (formations hospitalières) the surgical services shall be provided with: (1) such equipment as will absolutely guarantee the sterilization of instruments, water and all forms of dressings; (2) a complete roentgenographic outfit, including the requirements of fluoroscopy, and (3) a laboratory sufficiently equipped to perform histologic and chemical examinations and to carry out bacteriologic researches such as become constantly necessary in the course of the examination and treatment of patients.

A Move to Protect Pedestrians Against Mud-Splashing Autos

M. Georges Lemarchand, in a letter to the chief of police, has pointed out the advantages that would accrue if an order could be issued requiring all automobiles, and especially motor trucks, to be fitted with fenders similar to those used on the autobuses of the Compagnie générale des omnibus. On account of the bad condition of the streets owing to their being neglected during the war, M. Lemarchand thinks that pedestrians ought to be protected against mud splashes, which not only damage clothing, so expensive at this time, but also constitute a menace from the hygienic standpoint.

The Attendance at Swiss Universities During the War

According to the Economiste français, in the school year 1913-1914 there were 8,110 students matriculated at the Swiss universities, 6,775 of whom were men and 1,335 women. In 1918-1919 the total had fallen to 7,307, a reduction of 10 per cent., but there has been a still greater change in the relative representation of the sexes: 6,430 men as against 877 women. The number of men was reduced only 5 per cent., while the number of women had decreased 34 per cent.

A study of the proportion of different nationalities develops some interesting facts. In 1913-1914 there were 3,925 Swiss in attendance as compared with 4,185 foreigners. In 1918-1919 the figures had become 5,328 and 1,979, respectively, which was an increase of 36 per cent. in the Swiss representation and a decrease of 56 per cent. in the number of foreigners. The great decrease in the foreign representation was brought about chiefly by the Russians, the number of whom (Poles are included) fell from over 2,000 to 486. The Bulgarians decreased from 527 to 78, and the Germans from 528 to 320.

Swiss universities, in recent years, have been unusually well attended. Before the war they had 21.3 students (including those who had merely visiting privileges) per 10,000 inhabitants; France had only 11.6; Austria, 9.4; Germany, 9.2, and Italy, 6.8.

Personal

At one of its recent meetings the Academy of Medicine elected three foreign correspondents: Professor Banti of Florence, Dr. Van Ermengem of Ghent, and Dr. Pawinski of Warsaw.

LONDON

Nov. 26, 1919.

Refutation of Lombroso's Theories in Official Work on Criminology

The most important work on criminology that has appeared in this country, or indeed in any country, has just been issued by the government. In 1901, Dr. Griffiths, deputy medical officer of Parkhurst prison, formed the idea of subjecting a large number of prisoners convicted of certain similar offense to measurements to ascertain whether they showed any deviation from what might be regarded as the normal, or noncriminal type. The suggestion commended itself to his superiors, who recommended that the observations should be extended to the general body of convicts so that the existing theories of criminology, particularly those of Lombroso, might be tested. In conjunction with the medical officers of the chief convict prisons, a scheme was drawn up and the data were tabulated by the late Dr. Charles Goring, deputy medical officer of the prison service. In order that they might be subjected to study by modern statistical methods, the aid of Prof. Karl Pearson, director of the biometric laboratory at University College, was obtained, and Dr. Goring was detached from duty to work under him. The main conclusions are as follows:

The criminal type marked by physical and mental stigmata, as described by Lombroso, does not exist. As individuals, criminals possess no characteristics, physical or mental, which are not shared by all people. Criminality is not a morbid state akin to physical disease which can be diagnosed and established by pure observation. On the other hand, the "criminal" man is to a large extent a "defective" man, physically and mentally, and this "defectiveness," like many other human qualities, is determined more by nature than by nurture. A "criminal diathesis," a composite of mental and physical defectiveness, is recognized. Like other constitutional characters, it is subject to heredity. The influence of parental "contagion" is inconsiderable in comparison with the influence of heredity and mental defectiveness, which are the most important factors in the production of crime.

Dr. Goring's work illustrates the unreliability of conclusions drawn from rough observations. Three hundred criminals classified into three grades of intelligence were observed to discover if there were any appreciable association between height of forehead and intellectual capacity. Their foreheads were classified as low, medium or high. Of the intelligent group, 20.5 per cent. had low foreheads and 20.5 per cent. high foreheads; of the unintelligent group, 35.7 per cent. had low and 8.3 per cent. high foreheads; of the weak-minded group the corresponding figures were 46 and 8 per cent. The conclusion seemed to be that frontal development was associated with intelligence. Two years later, however, the same 300 criminals were included in a group of 800 criminals whose head-contours were being traced, and a series of precise measurements of the forehead heights were thus obtained. The verdict by the exact method was different. There was little, if any, appreciable relationship between height of forehead and intelligence.

No evidence was obtained of the existence of a physical criminal type, such as described by Lombroso and his followers. But English criminals are markedly below the general population in stature and body weight. Those convicted of violence to the person are characterized by an average

degree of strength and of constitutional soundness considerably above the average of the other criminals and of the law-abiding class. Thieves, burglars and incendiaries, who constitute 90 per cent. of all criminals, are inferior in stature and weight, and are puny in their general bodily habit in comparison with other criminals and with the law-abiding population. These are the sole facts on which the theories of criminal anthropology rest.

First convictions show a predilection for the age period from 15 to 25, which Dr. Goring concludes to be significant. Comparing this fact with the age incidences of liability to various diseases, he is inclined to interpret the facts as evidence that a "mental constitutional proclivity is the primal source of the habitual criminal's career." Alcoholism, epilepsy, sexual profligacy, and insanity in their relation to crime are accidental associations depending on a high degree of relation between defective intelligence and crime. It cannot be assumed from the evidence that defective intelligence is correlated with the defective physique. English criminals appear to be selected from the noncriminal population by two independent factors: a mental constitution and a physical constitution, each, however, differing from that of the general population in degree and not in kind. Moreover, elaborate examination of the data shows that crime, at least in this country, is due only in a trifling extent (if in any) to social inequality, adverse environment, or other manifestations of what may be comprehensively termed the "forces of circumstances."

The Prevention of Venereal Disease

The prevention of venereal disease continues to be the burning question in the lay press. The National Council for the Combating of Venereal Disease has published a letter in the *Times* stating that it is as firmly opposed as ever to any general distribution of prophylactic packets to the civil community. The council holds that the prevention of venereal diseases is a large sociomedical problem. In the direct line of attack, ample facilities for treatment and instruction of the public occupy the first place. Concerning personal disinfection after risk is taken, the council has always acknowledged the value of cleansing and disinfecting material applied early and thoroughly in diminishing the risk of disease. Abstention from exposure to infection is the only certain safeguard against the ordinary risk of the diseases. Continence is to be encouraged by every means. No person who has indulged in promiscuous sexual intercourse can be certain that he is not infected. He or she should therefore seek means of cleansing at the earliest possible moment. For this purpose a thorough application of soap and water is of great value, followed, if possible, by the use of such disinfectants as may be recommended by a physician. While such applications sensibly reduce the risk if applied within four hours of exposure, they afford no certain security. In the case of women, satisfactory self-disinfection is practically impossible; medical attention at the earliest possible moment is necessary.

Drunkenness as a Defense in Trial for Murder

A conviction for murder has been quashed under peculiar circumstances in the court of appeal. A man was convicted of an atrocious murder: strangling a girl of 13 while violating her. The defense was that the man was so drunk when committing the crime that the jury should find a verdict of manslaughter. During a discussion of the law, the judge said that if a man is violating a woman and she defends herself and the man does something which kills her, to prevent her from screaming or struggling, he commits murder. The defense of drunkenness could prevail only when it was proved that the accused did not know what he was doing or did not know that he was doing wrong. The court of appeal held that fatal violence done in furtherance of a felony, such as rape, was undoubtedly murder. As to drunkenness reducing the crime of murder to manslaughter, numerous decisions showed that for this to succeed the accused must be proved to be so affected by drink that he was incapable of knowing that what he was doing was dangerous. But the direction of the judge in the present case was less favorable to the accused. He had applied the test applicable to cases in which the defense was insanity. Had he applied the proper test it was impossible for the court to say what the verdict would have been. The court therefore concluded that the verdict must be reduced to manslaughter. The crime was of the gravest character. The sentence would be of the severest kind—penal servitude for twenty years.

Marriages

FRANCIS EDWARD TURGASEN, Marshfield, Wis., to Miss Gertrude Breitlow of Winona, Minn., November 28.

EDWARD NEWMAN PACKARD, Saranac Lake, N. Y., to Miss Mary Bissell Betts of New York City, November 27.

ARTHUR GIBBON KELLEY, Greenville, S. C., to Miss Louise Dobbs of Inman Park, Atlanta, Ga., November 18.

CLARENCE HENRY BOREN to Miss Gertrude Elizabeth Mueller, both of Marinette, Wis., November 22.

FREDERICK WALTER MASON, Great Neck, L. I., N. Y., to Miss Edith Bowron of Flushing, L. I., recently.

JOHN HUGHES DUNNINGTON to Miss Genevieve R. Parker, both of New York City, November 26.

ALBERT E. CAMPBELL, Springfield, Ill., to Miss Carrie Roberts of Decatur, Ill., November 26.

ROY J. HOLMES, Wadley, Ga., to Miss Esther Smith of Bartow, Ga., at Wadley, November 12.

BENJAMIN APPLEGATE FURMAN to Miss Helen Pryor, both of Newark, N. J., September 27.

WALTER JAMES SULLIVAN to Miss Katherine Agnes Keith, both of Chicago, November 29.

LUMIR ROBERT SAFARIK to Miss Madge Dunnell, both of New York City, October 18.

JOHN DANNA THOMSON to Miss Ruth Arnold, both of Atlanta, Ga., November 15.

JAMES LEONIDAS KING, Macon, Ga., to Miss Grace O. Ide of Baltimore, November 26.

RAYMOND FRANCIS WITELL to Miss Anna Conley, both of Pittsburgh, November 27.

ROBERT ELLIS WEAVER to Miss Ruby Scott, both of Hope, Ark., November 22.

WILLIAM JOHN SCHOLES to Miss Myrtle Bonnet, both of Chicago, recently.

Deaths

Robert B. Wilson, Montreal; McGill University, Montreal, 1893; aged 53; for many years superintendent of the Western Hospital, Montreal; a pioneer in roentgenology and electrotherapy; lieutenant-colonel, C. A. M. C.; who went overseas with the first Canadian contingent and was attached to Canadian General Hospital No. 1 in France, later to Granville Canadian Special Hospital, Ramsgate, England, from there was called to London and given charge of roentgenray work, and equipment of all Canadian hospitals overseas; consultant in electric and hydrotherapeutic treatment in Canada, and responsible for this equipment in all Canadian hospitals in the Dominion, with headquarters in Toronto; died in St. Andrew's Military Hospital, Toronto, November 1.

Robert Lee Randolph ● Baltimore; University of Maryland, Baltimore, 1894; aged 59; attending surgeon to the Presbyterian Eye and Ear Hospital; ophthalmic and aural surgeon in chief to the Baltimore and Ohio Railroad; chief surgeon to the Chesapeake Steamship Company; associate professor of clinical ophthalmology and otology in Johns Hopkins Medical School, Baltimore; winner of the Alverenga prize of the College of Physicians of Philadelphia in 1901; and the Boylston prize of Harvard University in 1902; died, December 9.

Robert John Sloan, Shanghai, China; University of Michigan, Ann Arbor, 1863; aged 81; assistant surgeon of the Thirtieth Missouri Volunteer Infantry, and later promoted to major and surgeon, during the Civil War; who went to Japan in 1869, and since 1877 had been located in Shanghai, China; died, June 5, from dropsy.

John Milton Tate, Fulton, Mo.; Bellevue Hospital Medical College, 1865; aged 77; representative from Calloway County in the legislature in 1893 and 1895; a director of the Calloway Bank, Fulton, and later of the Williamsburg Bank; died at his farm home, December 2, from cerebral hemorrhage.

Louis J. Goux ● Detroit; Detroit College of Medicine and Surgery, 1894; aged 48; a member of the American

● Indicates "Fellow" of the American Medical Association.

Academy of Ophthalmology and Oto-Laryngology; ophthalmologist and otologist to the Eastern Michigan State Hospital, Pontiac and Grace Hospital, Detroit; died, December 1.

Charles Arthur Vanderveer, Phoenix, Ariz.; College of Physicians and Surgeons in the City of New York, 1890; aged 72; formerly a practitioner of Long Branch, N. J.; and then a member of the staff of the Baltimore *Sun;* secretary of the Phoenix Board of Trade; died, December 8.

William Thomas Williams ● Mount Carmel, Pa.; University of the City of New York, 1875; aged 65; local surgeon of the Pennsylvania and Lehigh Valley systems; for twelve years head of the state department of health clinic at Mount Carmel; died, December 4, from pleuropneumonia.

Dwight Birdsill Hunt, Otego, N. Y.; New York Homeopathic Medical College, New York City, 1873; aged 73; for many years a member and dean of the faculty of his alma mater; a member of the staff of the Homeopathic Hospital, New York City; died, December 6.

Colon Junius Spence ● Milford, Ohio; Miami Medical College, Cincinnati, 1883; aged 61; president of the Claremont County board of education for ten years; for several years a member of the surgical staff of the Jewish Hospital, Cincinnati; died, December 3.

William Pinkney McKee, Washington, D. C.; George Washington University, Washington, D. C., 1903; aged 43; a member of the Medical Society of the District of Columbia, and a specialist in ophthalmology; died, November 30, from multiple sclerosis.

George Edwin Adams, Worcester, Mass.; Harvard University Medical School, 1880; aged 62; a member of the Massachusetts Medical Society; died suddenly from heart disease, November 29, while making a professional call.

William Wymond Walkem, Vancouver, B. C.; Queens University, Kingston, Ont., 1873; aged 69; in 1894 a member of the provincial legislature from the district of South Nanaimo; died, September 29.

Charles Franklin Updike, Capt., M. R. C., U. S. Army, Browntown, Va.; University of Maryland, Baltimore, 1889; aged 55; a member of the Medical Society of Virginia; died, October 14, from diabetes.

Albert Carlton Baxter ● Oswego, N. Y.; Albany (N. Y.) Medical College, 1896; aged 45; health officer of Oswego County; consulting physician to the Oswego Hospital; died, about December 1.

John Ellis Rodley, Chico, Calif.; Missouri Medical College, St. Louis, 1881; aged 67; for four years local surgeon of the Missouri Pacific System at St. Louis; died in Napa, Calif., December 2.

Joseph John Cronin, Boston; Jefferson Medical College, 1885; died in the Peter Bent Brigham Hospital, Boston, November 30, from septicemia, due to an infected wound of the hand.

James Casey, Chicago; Northwestern University Medical School, Chicago, 1902; aged 68; a member of the Illinois State Medical Society; died, December 10, from chronic nephritis.

Thomas B. Hayward, Baltimore (license, Maryland State Board of Medical Examiners); aged 83; a practitioner for nearly half a century; died, December 9, from senile debility.

Thomas McFadden, Syracuse, N. Y. (license, N. Y., 1878); aged 81; for many years a practitioner of Appleton, N. Y.; died at the home of his daughter in Syracuse, December 4.

Vernon Clayton Goodrich ● Barre, Vt.; University of Vermont, Burlington, 1873; aged 73; postmaster of Brookfield, Vt., for four years; died, November 29, from pneumonia.

Christopher A. Frame, Roxboro, Philadelphia; Penn Medical University, Philadelphia, 1876; aged 73; a veteran of the Civil War; died, December 12, from heart disease.

John D. Mutters, Ashland, Ky.; Starling Medical College, Columbus, Ohio, 1892; aged 66; a member of the Kentucky State Medical Association; died, about December 1.

Thomas G. G. Ritchie, Cochran, Alta.; F.R.C.S. (Edin.), 1872; who was seriously injured in a motor accident near Banff, Alta.; died in a hospital at Calgary, October 5.

Harry Cook, Urbana, Ohio; Chicago Homeopathic Medical College, 1894; aged 46; died in Grant Hospital, Columbus, Ohio, December 1, from organic heart disease.

Edmund G. Shower, Baltimore; Hahnemann Medical College, Philadelphia, 1878; aged 73; died suddenly, December 10, from neuritis, complicated by heart disease.

Millard F. Pritchard, Cherokee, Iowa (license, years of practice, Iowa, 1886); aged 67; a practitioner since 1874; died, November 22, from pernicious anemia.

William R. Smith, Pinckard, Ala.; Memphis (Tenn.) Hospital Medical College, 1886; aged 56; died in a hospital in Dothan, Ala., November 24, from dropsy.

J. Bruce Hess, Benton, Pa.; Jefferson Medical College, 1892; aged 58; died in the George F. Geisinger Memorial Hospital, Danville, Pa., November 28.

Edwardo S. Navaun, Detroit (license, Michigan, seven years of practice, 1900); aged 66; a practitioner since 1872; also a druggist; died, November 27.

August A. Guglieri, Madrona, Calif.; California Eclectic Medical College, Los Angeles, 1901; aged 60; formerly of San Francisco; died, November 30.

Charles Schomberg Elliott, Toronto; Harvard University Medical School, 1860; aged 80; a specialist on nervous and mental diseases; died, October 24.

Jessie M. Green Estes, Chicago; Saginaw Valley Medical College, Saginaw, Mich., 1902; aged 50; died, November 28, from an overdose of chloroform.

William Charles Rutledge, Denison, Texas; Hospital College of Medicine, Louisville, Ky., 1898; aged 58; died, November 8, from tuberculosis.

Henry John Charles Sprehn, Reno, Nev.; California Eclectic Medical College, Los Angeles, 1913; aged 42; died in Oroville, Calif., November 13.

Albert Riley Cain ● Cambridge, Ohio; Columbus (Ohio) Medical College, 1892; aged 69; died, November 30, from cerebral hemorrhage.

William R. Eareckson ● Elkridge, Md.; University of Maryland, Baltimore, 1890; aged 52; died, December 10, from cerebral hemorrhage.

Alfred Raymond ● Seattle; McGill University, Montreal, 1886; aged 59; died in Rochester, Minn., December 3, after a surgical operation.

May E. Tracey Callender, Middletown, Conn.; New York Medical College and Hospital for Women, 1865; aged 83; died, November 1.

Romanus M. Smith, Manzanola, Colo.; University of Louisville, Ky., 1885; aged 65; died in Long Beach, Calif., November 24.

James T. Sweetman, Ballston Spar, N. Y.; University of Georgetown, Washington, D. C., 1872; aged 85; died, October 21.

Anthony I. Hoon ● Mercer, Pa.; University of the City of New York, 1881; aged 63; died, December 6, from heart disease.

Charles Wesley Pillsbury ● Saco, Me.; Dartmouth Medical School, Hanover, N. H., 1881; aged 68; died, December 3.

Edwin H. Sims, Columbus, Ga.; Atlanta (Ga.) Medical College, 1883; aged 57; died, November 28, from heart disease.

John W. Scott, Jamestown, N. Y.; Cleveland University of Medicine and Surgery, 1866; aged 80; died, November 5.

Elbridge Simpson Pixley, Pittsfield, Mass.; Eclectic Medical College, Philadelphia, 1878; aged 87; died, October 12.

William Henry Mays, Newman, Calif.; University of California, San Francisco, 1873; aged 73; died, November 30.

George M. Overstreet, Sylvania, Ga.; University of Virginia, Charlottesville, 1892; aged 50; died, December 1.

William Caswell Maples ● Scottsboro, Ala.; University of Nashville, Tenn., 1881; aged 61; died, November 24.

Alois F. Juettner, Cincinnati; Cincinnati College of Medicine and Surgery, 1890; aged 67; died, November 27.

Martha Hays Pollock, Harrisburg, Pa.; Boston University School of Medicine, 1893; aged 74; died, December 2.

William A. Marner, Miles, Iowa; State University of Iowa, Iowa City, 1885; aged 61; died, December 10.

George H. Miller, McDonald, Pa.; Miami Medical College, Cincinnati, 1873; aged 73; died, November 30.

Charles S. Wight, Marlboro, Mass.; University of Nashville, Tenn., 1880; aged 63; died, December 3.

Bennett G. Willis, Omaha; John A. Creighton College, Omaha, 1906; aged 38; died, November 26.

Milo Leonard Kensington, Chicago; University of Illinois, Chicago, 1891; aged 72; died, December 4

William J. Humphrey ● Union City, Pa.; University of Buffalo, 1890; aged 58; died, October 19.

Correspondence

"DEFECTS IN THE TEACHING OF PATHOLOGY, AND THE LAY PROFESSOR"

To the Editor:—I have been both interested and instructed by the communications of Dr. Douglas Symmers (THE JOURNAL, Sept. 20, 1919) and of Dr. Francis Carter Wood (Dec. 6, 1919) relative to the regrettable falling off in the percentage of necropsies performed in our representative hospitals. As the resident medical officer of the Philadelphia General Hospital (Blockley), this fact has caused me considerable concern.

There were in our wards 3,235 deaths in 1918, 535 of this number occurring from September 23 to November 1, during the epidemic of influenza. Of this number, 6.83 per cent. were posted. During the height of the epidemic, the work in the postmortem room was at a standstill, for more pressing work demanded the attention of all. From Jan. 1, 1919, to June 30, 1919, 1,324 deaths occurred in our wards, of which 108 necropsies were performed in our hospital morgue.

Early in June, before the new class of interns reported for duty, I endeavored to discover some plan for increasing our necropsy service. It was decided that each month a postmortem efficiency sheet should be published, in which the percentage of postmortems and deaths in each service should be set forth in order of rank.

Each visiting physician was also to be notified on a printed form, drawn up for that purpose, of his percentage for the current month. Talks were given the intern staff on the unquestioned teaching value of comparing clinical and pathologic diagnoses. The result was indeed gratifying, as will be shown by the accompanying table for the months of July, August, September, October and November.

PERCENTAGES OF NECROPSIES

Month	Deaths	Necropsies	Average Per Cent.
July	176	41	23.06
August	162	40	24.69
September	131	44	33.58
October	117	45	38.46
November	150	36	24.00

A low postmortem percentage can often be traced to failure on the part of the visiting physician to make known specifically the fact that he expects each case studied in his ward to be posted, if death occurs. But this is not enough, for interest will soon languish unless a resident hospital officer not only does all in his power to simplify the method of securing postmortem permissions, but also continually impresses on the resident staff that a high percentage is expected of each intern, and that his efficiency record shall contain accurate information as to the practical results of his endeavor to secure such permissions. It is not felt at the Philadelphia General Hospital that an intern is interested and efficient, and worthy of the highest commendation, unless his postmortem percentage remains consistently high.

The difficulties encountered at the Bellevue, Boston, and the Philadelphia City hospitals, are similar.

In Philadelphia, by special concession of the state anatomic board, we are allowed to perform necropsies on 35 per cent. of our unclaimed dead from October to June, and 25 per cent. during the summer months.

The coroner's office does not materially increase the number of examinations held at the Philadelphia General Hospital, as permissions are required from the relatives on all coroner's cases, except those in which violence is suspected.

It has been found that the most fruitful procedure to adopt is to secure the written permission before death takes place. The verbal permission, legal in Minnesota and possibly a few other states, removes one of the great stumbling blocks to solving this problem, and probably explains the high percentage of examinations reported from hospitals in these localities.

Finally, as is suggested by Dr. Wood, there exists a direct ratio between the perseverance and interest that the visiting and resident staffs display and the number of examinations performed. Postmortem examinations can be secured in a large percentage of cases if intelligent and wideawake effort is persistently made.

JOSEPH C. DOANE, M.D., Philadelphia.
Chief Resident Physician, Philadelphia General Hospital.

To the Editor:—I have read Dr. Hammett's reply to my article on this subject (THE JOURNAL, Dec. 13, 1919, page 1852) in which he refers to my "stigmatization" of the so-called lay professor in the medical school as untimely and as showing lack of appreciation of the contributions of such men to medical progress.

I regret that my statements should have been interpreted as an effort to stigmatize gentlemen for whom and for whose accomplishments I entertain respect and admiration. I made no reference to the scientific achievements of nonmedical men which, from Pasteur onward, have been universally acclaimed, but confined myself to criticism of the value of nonmedical men as teachers in the medical school. Doubtless the nonmedical professor is a necessary factor in that stage of evolution through which the schools are now passing, since modern medicine has failed, among other things, to provide its own teachers in the more strictly scientific branches; but I venture to predict that, as time goes on, he will be replaced by an educator whose knowledge of medicine will have been developed by a broader experience than that of the laboratory alone. As it stands now, the medical curriculum is overloaded, not only in the fundamental branches, but elsewhere. In the grave responsibility of proportioning the teaching of physiology, biologic chemistry and anatomy, and in the choice and emphasis of facts to be presented to the student, I believe that we shall ultimately receive more valuable assistance from the properly trained physician than from the highly specialized products of the schools of science.

DOUGLAS SYMMERS, M.D., New York.

"TEST FIGHT ON SOCIAL INSURANCE IN NEW YORK"

To the Editor:—There is cold comfort for the medical profession of New York in the editorial announcement in THE JOURNAL, December 6, p. 1774, of the coming effort of the governor of this state, backed by the New York State Federation of Labor, to put through the scheme for compulsory health insurance at the coming session of the state legislature.

After wrestling with this matter for four years, the Medical Society of the State of New York has definitely gone on record against it. This step was taken at a special meeting of the House of Delegates called to discuss the subject. The New York County Medical Society has long been on record as opposed to the "principles" of compulsory health insurance. Nevertheless, much of the vitality of this measure has been due to the pleas for "constructive" work and for "study" of it by the influential not to say the ruling portion of this body.

The present attitude of the county society on this question is one of unanimous disapproval. This was brought about by the exigencies of an election contest, just closed, in which both sides were compelled to declare their opposition to compulsory health insurance as a matter of safety.

In the same way, it may be stated, the state society was compelled to take a definite stand by the growth of associations, leagues and guilds of medical men organized to oppose this measure more effectually than had been done in their opinion by their local and state organizations.

For four years the medical men of New York state have been compelled to fight this battle at each session of the legislature, at a loss of time and at an expense of money which many of them could ill afford against paid public servants and others who were not losing anything by advocating a system of compulsory health insurance. At my suggestion last year, the late president of the Medical Society of the State of New York, Dr. Thomas H. Halsted, called the attention of all the county societies of the state to this matter early in the session of the legislature instead of waiting for the perfunctory hearing toward the close of the session to take action on it. Again this year I advised an active discussion of the subject by medical men with their candidates for the assembly well in advance of the date of election, instead of waiting till after this event, as was the case in its discussion by the state society.

In your article you say that New York "is an ideal state in which to discuss and test out this important subject." Judging by the facts given above, it has been tested out by medical men in this state, not only to their hearts' content, but to their hearts' sorrow. For them the discussion is closed. An official presentment of this fact by the Medical Society of the State of New York duly attested to the governor and the legislature should be the only action on their part at the coming session of the legislature in regard to compulsory health insurance. If this measure is to be enacted into law, let it be definitely understood that the great body of the medical profession of New York will have to be impressed into carrying out its medical provisions by the hand of the state, a form of compulsory medical service which the people will not be slow to recognize as one in every way inimical to their interests and unworthy of the traditions of the great medical profession.

JOHN P. DAVIN, M.D., New York.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

GRADUATE COURSES IN PUBLIC HEALTH

To the Editor:—Please let me know if any medical school in Chicago grants a degree in public health, and if any of this work can be done during the summer. ETTA SELSAM, M.D., Indianapolis.

ANSWER.—No medical school in Chicago gives public health courses leading to a degree. A list of the schools giving such courses and a description appeared in THE JOURNAL, Aug. 16, 1919, page 516.

The New Netherlands Law on Narcotics.—Although the three international conferences on regulation of the consumption of opium, etc., were held in the Netherlands (1911, 1913 and 1914), and France, England and the United States have long since passed laws, the Netherlands completed its legislation on the subject only in October, 1919. The law of Oct. 4, 1919, is said to be a model of conciseness and allows fewer loopholes for infringement of the spirit of the law than the more extensive and sometimes galling laws of the other countries. A full summary of the law is given in the *Nederlandsch Tijdschrift voor Geneeskunde* **2**:1577 (Nov. 15), 1919, with comment by Professor Muntendam. He says that the abuse of narcotics is almost negligible in the Netherlands in comparison with other countries. But the new law will prevent importation of the vice of drug addiction just as the legislation against absinthe has prevented the development of absinthe abuse. He adds that the benefit from a law depends on the way in which it is enforced, and in this case much depends on the decisions of the committee who are to pass judgment on the narcotic content, etc., of "patent medicines" and other proprietaries and nostrums.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 13. Chairman, Dr. Samuel W. Welch, Montgomery.
ARIZONA: Phoenix, Jan. 6-7. Sec., Dr. Ancil Martin, 207 Goodrich Bldg., Phoenix.
COLORADO: Denver, Jan. 6. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.
DISTRICT OF COLUMBIA: Washington, Jan. 13. Sec., Dr. Edgar P. Copeland, The Rockingham, Washington.
HAWAII: Honolulu, Jan. 5-8. Sec., Dr. J. R. Judd, Honolulu.
INDIANA: Indianapolis, Feb. 10-13. Sec., Dr. W. I. Gott, 84 State House, Indianapolis.
KANSAS: Topeka, Feb. 10. Sec., Dr. H. A. Dykes, Lebanon.
MINNESOTA: Minneapolis, Jan. 6-9. Sec., Dr. Thos. McDavitt, Lowry Bldg., St. Paul.
MISSOURI: St. Louis, Jan. 12-14. Sec., Dr. George H. Jones, State House, Jefferson City.
NATIONAL BOARD OF MEDICAL EXAMINERS: St. Louis and Chicago, Feb. 18-25. Sec., Dr. J. S. Rodman, 1310 Medical Arts Bldg., Philadelphia, Pa.
NEW MEXICO: Santa Fe, Jan. 12-13. Sec., Dr. R. E. McBride, Las Cruces.
NEW YORK: New York City, Albany, Buffalo, Syracuse, Jan. 27-31. Asst. Professional Examinations, Mr. H. J. Hamilton, Albany.
NORTH DAKOTA: Grand Forks, Jan. 6. Sec., Dr. George M. Williamson, Grand Forks.
OKLAHOMA: Oklahoma City, Jan. 13-14. Sec., Dr. J. M. Byrum, Shawnee.
OREGON: Portland, Jan. 6. Sec., Dr. Frank W. Wood, 559 Morgan Bldg., Portland.
PENNSYLVANIA: Philadelphia, Jan. 13-17. Pres., Dr. John M. Baldy, Harrisburg.
RHODE ISLAND: Providence, Jan. 2-3. Sec., Dr. B. U. Richards, State House, Providence.
SOUTH DAKOTA: Pierre, Jan. 13. Sec., Dr. Park B. Jenkins, Waubay.
VERMONT: Burlington, Feb. 10-12. Sec., Dr. W. Scott Nay, Underhill.
WASHINGTON: Spokane, Jan. 6-8. Sec., Dr. C. N. Suttner, 415 Old National Bank Bldg., Spokane.
WEST VIRGINIA: Charleston, Jan. 13. Sec., Dr. S. L. Jepson, Masonic Bldg., Charleston.
WISCONSIN: Madison, Jan. 13-15. Sec., Dr. John M. Dodd, 220 E. Second St., Ashland.

GRADUATE MEDICAL EDUCATION IN GREAT BRITAIN AND FRANCE

LOUIS B. WILSON, M.D.
ROCHESTER, MINN.

At the meeting of the Executive Committee of the Council on Medical Education of the American Medical Association, Feb. 3, 1918, the Committee on Graduate Medical Degrees appointed the previous year was continued, and its duties enlarged to include a study of the entire problem of graduate medical instruction in this country and in the countries of our allies. The personnel of the committee is as follows: Louis B. Wilson, chairman; N. P. Colwell, secretary, and Isadore Dyer, John M. Dodson, A. C. Eycleshymer, William Pepper, Jr., Victor C. Vaughan, J. M. T. Finney, Edward Jackson, and James Ewing.

The chairman of the committee was instructed, should he be ordered to military duty in Europe, to make such observations and collect such information concerning graduate medical education there as time and opportunity would permit. It so happened that he was stationed in London during April, 1918, and in France from April, 1918, to June, 1919, except for a brief visit again to England in April, 1919. During this time he had conferences with Sir William Osler, chairman of a committee representing the London medical schools; with Sir George Makins, Prof. Arthur Keith and Sir Arbuthnot Lane of London; Sir Berkeley Moynihan of Leeds; Sir Robert Jones of Liverpool; Sir Harold Stiles and Sir William McCormack of Edinburgh; Col. J. G. Adami of the Canadian Medical Service, and with Sir Walter Morley Fletcher of the Medical Research Committee. In France similar conferences were held with Prof. Henri Roger, dean of the Faculty of Medicine of the University of Paris; M. Georges Destouches, secretary of the faculty; Dr.

Calmette, one of the directors of the Pasteur Institute; Dr. A. Béclère, president of the Association médical de Hôpitaux de Paris; Prof. A. Policard of the Lyons Medical School, and numerous other French medical officers met incidentally. Conferences were also held with Mr. George H. Nettleton, director of the American University Union in Europe, and Dr. George E. MacLean, acting director of the British branch of the American University Union. No opportunity was afforded for the study of the graduate medical situation in Italy, although incidental information would indicate that in certain of the schools there are opportunities for Americans to work to advantage, particularly in laboratory subjects. The results of the observations in Great Britain and France are herewith presented as an interim report in the hope that the information may be of use to some of the many Americans now seeking opportunity for graduate medical study.

GREAT BRITAIN

The numerous three-months' courses in medicine which were attended by about 300 medical officers of the American Expeditionary Forces after the armistice furnished many suggestions to the instructors, particularly in the London and Edinburgh medical schools, concerning the kind of work desired by American graduate medical students. They also demonstrated to American medical students the high quality of work to be had even under the adverse conditions then obtaining. On the basis of this experience, Sir William Osler's committee has formulated, with the cooperation of the twelve London undergraduate medical schools, the four existing postgraduate institutions and many hospitals, a plan for lectures in the fundamental medical subjects, clinical teaching in cases in wards and outpatient departments, and practical instruction in roentgen-ray diagnosis, pathologic chemistry, bacteriology, clinical microscopy, postmortems, etc. The cooperation of the British medical schools outside of London will probably soon be secured. Special research work and clinical assistantships are also available to qualified men. Many of these courses will be most excellent, and American graduates in medicine will greatly appreciate them.

The central organization consists of a council made up of representatives of all the participating teaching institutions, and representatives of the board of education, the Medical Research Committee, the dominions, and American universities. This governing body assists in the organization of courses, maintains a uniformity of fees in the various schools, and furnishes detailed information concerning courses. Ultimately the association will have a building in central London not only containing offices of the organization but also forming a meeting place for medical graduates of the empire and the allied nations. American students desiring detailed information concerning the courses available should correspond with the director of the American University Union, 16 Pall Mall, East, S.W. 1, London, or with Sir William Osler, 13 Norham Gardens, Oxford.

Recently a union has been accomplished between the Osler group for graduate study and the American Hospital of London. The latter institution, which was developed largely through the activities of Sir Arbuthnot Lane, has the financial support of a number of influential Americans and Englishmen in London. It is proposed to build a large hospital well equipped not only for the care of patients but also for clinical teaching and laboratory research work. The patients may be derived from any available source. The attending medical officers will be recruited from among the most eminent of the London members of the medical profession, while the house officers, interns and graduate students will be made up of Americans. Any one desiring information concerning the opportunities offered in this hospital should inquire of Mr. Phillip Granklin, No. 1 Wimpole Street, S. 1, London.

Information at present is not at hand concerning the graduate courses in medicine actually open to American medical students in the British medical schools outside of London. It is known, however, that there are such opportunities, particularly at Edinburgh and Liverpool. Information concerning these may be obtained direct from the secretaries of the faculties.

American medical students, of course, will find great variation in the kind and quality of the teaching by the individual instructors in Great Britain. In general, however, they may expect to find the British medical man a thoroughly trained clinician, a sturdy advocate of the unvarnished truth, not taking kindly to unsupported hypotheses, without much reverence for supposedly established medical "authorities," and in criticism likely to hew to the line, let the chips fly where they may. His personal atmosphere contains no "London fog," and is delightfully "bracing."

FRANCE

In France, though all medical education is under the general control of the minister of education, each medical school has its own peculiarly individual plan of work. During the war the French medical schools were almost completely disorganized, but they have made rapid progress at reorganization since the armistice. Perhaps the graduate work most readily available to American medical students in France at present is that offered by the Association des Hôpitaux de Paris, of which Dr. A. Béclère, 122 Rue la Boëtie, is president. This organization, which was formed in 1907, contains a large number of the most prominent physicians, surgeons and specialists in Paris, who have associated themselves together for the better utilization for teaching purposes of the clinical material which they control in the various hospitals. The courses offered by the different members of the association are announced annually in a bulletin which may be obtained from the president of the association. Whatever divergence of interests may have previously existed between the teachers of this association and the School of Medicine of the University of Paris has now been corrected, and the two are working together in harmony for the development of graduate medical education.

In cooperation with these French organizations is the American University Union in Paris and the "College of the United States of America." Mr. George H. Nettleton, director of the American University Union, Paris, during the war interested himself not only in the purpose for which the American University Union was primarily formed, that is, "to meet the need of American university and college men and their friends who are in Europe for military or other service in the cause of the Allies," but also in the promotion of a broad basis of better relationships between the educational interests of the United States and France. Through M. André Tardieu, Commissaire Général des Affaires de Guerre Franco-Américaine, and M. Coville, director of higher education, he did much to bring about an understanding of the need of American university students and of what the United States has to offer to French university students. The American University Union has been given a grant of land in Paris on which to place a building for its general headquarters. Funds for the erection of such a building are now being obtained. This building will no doubt become a general meeting point and source of information for university students in France. Graduate medical students desiring information concerning the courses available should correspond directly with the American University Union at 8 Rue de Richelieu, Paris.

"The College of the United States of America," which is incorporated under the laws of the State of West Virginia,

with its principal office at 24 Boulevard des Capuchines, is supported by a number of wealthy Americans resident in Paris. It announces that "the object of this organization is to create in Paris an institution of learning to promote intellectual rapprochement between France and the United States, to constitute a clearing house for the exchange, discussion and dissemination of ideas in all the various branches of education, science and learning, and finally to constitute a sort of administrative home for students in France. It proposes by way of beginning to establish immediately in Paris an office or bureau as the headquarters of the new institution where may be found a complete list of the teaching facilities of France with the names of all the well known savants willing to accept graduate students in their classes, clinics and laboratories."

Outside of Paris, probably the best opportunities for graduate study of medicine in France will be found at the medical schools of Lyons, Lille and Strasbourg. All of these are in the process of reorganization and will soon be able to offer good opportunities for graduate study.

An American graduate medical student who has command of the French language will find study in France most inspiring. The Frenchman has none of the wearying, plodding methods of the Teuton, but he arrives at his conclusions across lots, apparently by intuition, actually by the subconscious guidance of wide clinical experience and a wonderfully clear mental vision, which is a racial characteristic.

French university undergraduate medical teaching in some places has not materially advanced since the days of Louis, Oliver Wendell Holmes' great instructor; but the Frenchman is an intense individualist, and the American medical student who seeks inspiration in almost any clinical specialty or in research by search can find some great teacher in France who is sure to give him a new and original point of view. Mention may be made of the special excellence of French work in the roentgen ray, diseases of the nervous system, skin and venereal diseases, and ophthalmology.

EXPENSES

The expenses of American graduate medical students in England and France, except for the ocean travel, should not be materially greater than in the United States. It is to be hoped that endowed traveling fellowships for study in these countries, paying at least as high a stipend as those provided for graduate medical study in the United States, may soon be greatly increased in number.

THE INSTITUTE OF INTERNATIONAL EDUCATION

This article would be incomplete without mention of the Institute of International Education, 421 117th Street, New York City, under the patronage of the Carnegie Foundation, which is now promoting an extensive plan of exchange of instructors between the United States and allied countries, and which later, I believe, expects to develop a similar plan for the exchange of students.

New Mexico April Examination

Dr. R. E. McBride, secretary of the New Mexico Board of Medical Examiners, reports that eight candidates were licensed by endorsement of their diplomas, and one candidate was licensed by reciprocity at the meeting held April 14-15, 1919. The following colleges were represented:

ENDORSEMENT OF DIPLOMAS

College	Year Grad.
Cooper Medical College	(1912)
Atlanta College of Physicians and Surgeons	(1899)
Chicago Medical College	(1881)
University of Maryland	(1914)
Harvard University	(1886)
University of Michigan Medical School	(1909)
Marion-Sims College of Medicine	(1892)
Jefferson Medical College	(1908)

LICENSED THROUGH RECIPROCITY

College	Year Grad.	Reciprocity with
University Medical College of Kansas City	(1906)	Missouri

Book Notices

THE HEALTH OF THE TEACHER. By William Estabrook Chancellor. Cloth. Price, $1.25. Pp. 302. Chicago: Forbes & Company, 1919.

According to the notice on the cover, this book discusses every question of hygiene associated with the teaching life "in a clear, practical way by a recognized authority." One of the four reasons given in his preface for the preparation of the book is that "such books as have appeared for adult teachers have not been written by men with medical training and experience, but by teachers of hygiene who have considered the subject pedagogically rather than medically." The author also states that the book is the outgrowth of early studies in physiology and hygiene and medical training followed by thirty years of educational experience.

While not a graduate of a medical school, the author has apparently read widely along medical lines. The book is a queer mixture of practical advice and common sense with sweeping generalizations and unwarranted statements on pathologic and hygienic questions. Evidently the author has been deeply impressed with the present day discussion of the ductless glands and their functions, and is unable to separate the working hypotheses of physiologic research workers from accepted scientific fact. His physiologic views may be gaged by a few extracts. "Meats seem to stimulate all the ductless glands. Conversation, public speech, social relations, serious reading, hard exercise such as horseback riding, tea, coffee, chocolate, the alcoholic stimulants . . . and sugar, one and all stir up these glands, especially the suprarenals." A deficiency of pituitary gland secretion "causes one to develop thin, blue flesh and fat and to be nervously weak, while an excess of its secretion causes thick, red flesh and fat and high passions." The human race is divided into five different "temperaments," namely, ideomotor, sinewy-motor, muscular-motor, vital corpulent and anemic sedentary, and the various mental, moral and physical peculiarities of each class are laid down with a definiteness and minuteness that reminds the reader of a "patent medicine" almanac or a popular handbook of astrology. Dementia is "loss of mind from fret and misunderstanding and brooding." There is no mystery about cancer. It is simply "a natural growth gone to mad excess." Tight collars are "very bad for the thyroid gland." Diabetes is due to a "liver distorted and almost separated into two parts from tight dressing in early youth." The "cases" that are reported as proof of the various theories advanced are most interesting. Patient 3 was "twice turned over as dead, once at 25 years of age and the second time at 40 years." The second collapse was due to the wearing out of the organs of secretion. It was not, however, "due wholly to errors of diet, but in part to a concussion of the spine at the point of exit and entry of the kidney nerves. Massage, pediatrics, and physiological rest have cured the spine at this point." Evidently there are brilliant results to be secured by the use of "pediatrics" in the treatment of a 40 year old patient, even in one whose "kidney nerves" are concussed. Patient 10 "drank enormous amounts of seltzer, so enormous that his skin was bleached and his kidneys bloated by excessive water." The reader is advised to purchase a blood pressure machine which "any teacher can learn to operate." A case of severe and prolonged typhoid fever could not be accounted for until an unsoldered soil pipe joint was found "directly below the clothes closet" of the victim.

The fact that this book has been published by a well-known firm which is evidently under the impression that it is reliable and authoritative on medical questions only makes it the more dangerous. If all of the advice contained in it were bad, it would defeat its own purpose. As it is, the good and the bad are so thoroughly mixed that it is impossible for the lay reader to separate them. Professor Chancellor should leave the preparation of books on hygiene to those qualified by training and experience to write them, or should at least have his manuscript revised by a competent authority before publication.

Medicolegal

Loss of Time Partly Under Influenza Regulation

(Newman v. Garfinkel et al. (N. Y.), 176 N. Y. Supp. 530)

The Supreme Court of New York, Appellate Term, First Department, in reversing a judgment that was rendered in favor of the plaintiff, says that he was employed under a written agreement to work for the defendants a period of twenty weeks at the rate of $27 a week. The hours of labor were from 8 in the morning until 6 at night, with time out for lunch and a half holiday on Saturday. In other words, the week consisted of forty-nine hours of labor. Loss of time was deducted on a pro rata basis at so much an hour. In the the course of the contract period the city was visited by the epidemic of influenza, and the board of health passed a resolution fixing the hours of employment in the defendants' factory from 9:30 a. m. to 5:30 p. m. One of the defendants testified that he called the workmen together, and that they agreed to change the hours from 9:30 a. m. to 7:30 p. m. He also testified that thereafter they flatly refused to continue work at night, and that the plaintiff regularly went home at 6 o'clock. This continued over a period of four weeks, and the plaintiff's time was deducted accordingly. In this action he sued to recover the amount of payment thus withheld, and was awarded a verdict for the full amount, on the theory that he was ready, willing and able to do the work at the rate of forty-nine hours a week. Yet by his own testimony he voluntarily left the factory an hour and a half before quitting time because, as he said, "there was not enough work for us to do." This evidence demonstrated that he took the hour of departure into his own hands, and that the breach of contract, if any, was on his own part. The judgment in his favor is therefore reversed, with $30 costs, and the complaint dismissed on the merits.

Physician Not Liable for Burning of Patient

(Malkowski v. Graham (Wis.), 172 N. W. R. 785)

The Supreme Court of Wisconsin, in affirming a judgment of the circuit court, which reversed one for $300 and costs that was rendered in favor of the plaintiff, says that the main question was whether the evidence was sufficient to support a verdict finding the defendant guilty of negligence. The defendant was called to perform an operation on the plaintiff's wife. At the time of the operation a Mrs. Lenga was in the employ of the plaintiff, or of his wife, to take care of the plaintiff's children, and at the request of the defendant placed a hot stove lid in the bed to warm it, which it was claimed burned Mrs. Malkowski's feet. Mrs. Lenga was a married woman 25 years of age, had two children, was related to the plaintiff, and was an intelligent, competent person, but had had no experience as a nurse. There was no evidence in the record that the defendant told Mrs. Lenga to put the irons on the feet of the patient. Giving the evidence the most favorable construction for the plaintiff, it was that the defendant told Mrs. Lenga to place the irons in the bed at or around the patient's feet, not on her feet. Moreover, Mrs. Lenga was as competent to judge whether the iron was hot enough to burn as was the defendant, and was as competent to know that if it was hot enough to burn, it should not be placed on the patient's feet. The defendant had a right to rely on Mrs. Lenga's knowledge and believe that she would not so place the iron as to burn the patient. Whether the iron was hot enough to burn was within the common knowledge of any person of the intelligence and experience of Mrs. Lenga. The negligence, if any, on the undisputed evidence was the negligence of Mrs Lenga, not the negligence of the defendant. It was insisted that Mrs. Lenga was the agent of the defendant, and that the relation of master and servant existed; but the evidence did not support that theory. Mrs. Lenga was in the employ of the plaintiff or of his wife. It was further claimed that the defendant was negligent in ordering Mrs. Lenga to place the hot iron in the bed. But the most that could be said in favor of the plaintiff's theory of the evidence was that the defendant told the person in charge of the patient and her children to keep her warm by placing warm or hot stove lids in bed with her, and, construing this evidence in the most favorable light for the plaintiff, it could not mean that the iron was to be placed so as to burn the patient. Clearly the defendant could not anticipate that anything of the sort would be done; hence one of the essential elements of proximate cause, namely, reasonable anticipation, was wanting in the proof. The defendant could not have anticipated that an ordinarily prudent and intelligent person would so place the iron as to cause the injury complained of; and, when there is no evidence to support the essential element of reasonable anticipation, proof is not sufficient to make a case. In order to charge the defendant with damages in this case, it must appear from the evidence that the defendant ought to have anticipated that the persons in charge of the patient would place the iron in the bed at such a heat and temperature and in such a position against the body of the patient as to burn her. On this point this court is of the opinion that there was no evidence sufficient to support a verdict for the plaintiff, and hence that the defendant was not guilty of negligence.

Information as to Attendance and from Necropsy Not Privileged

(Chadwick v. Beneficial Life Insurance Co. (Utah), 181 Pac. R. 441)

The Supreme Court of Utah says that in this action on a policy of life insurance, where the defendant alleged that the insured had in his application for insurance falsely answered certain questions asked him by the medical examiner, a physician called as a witness was asked as to whether he had been consulted by the insured prior to his application for insurance, and he answered, "Yes." He was then asked if he had been consulted on more than one occasion and, over the objection of the plaintiff, was permitted to answer that he had. The ground of the objection was that the witness was prohibited by statute from answering. The Utah statute prohibits physicians, without the consent of their patients, from testifying in a civil action as to any information acquired in attending a patient which was necessary to enable the physician to prescribe or act for the patient. The question asked did not call for the disclosure of such information, but was limited entirely to the fact as to whether the witness had been consulted by the insured. It was not within the statute, and under the issues the testimony was properly admitted.

The same witness later in his examination, against the objection of the plaintiff, was permitted to testify that he performed a necropsy on the body of the insured a day or two after his death, and found that he had died of tuberculosis of the spine. He testified also as an expert, in substance, that the disease and conditions were such that the insured would know he was not in good health for two and a half months before his death. As the policy was applied for about the last of May and the insured died on the 13th of August next following, this testimony was elicited manifestly for the purpose of showing that the insured must have known that he was afflicted with disease when he applied for insurance. The statute above referred to was invoked and relied on in support of this objection. The grounds of the objection were untenable from every point of view. The privilege claimed does not exist at common law. It was conferred by statute. In order to be available the claim of privilege must be brought within the clear meaning and spirit of the statute. Just how information acquired by means of a necropsy can be said to have been acquired to enable the physician to prescribe or act for the patient presents to the mind of the court an insoluble question. When the patient is dead he is no longer a patient. The only functionaries that can thereafter be said to act for him are the undertaker and the gravedigger, and as to them the statute is silent. If it had been necessary for the witness to supplement the information acquired at the necropsy by information he acquired during his attendance on the patient, in order to determine the cause of his death, a different question would be presented.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Anatomy, Philadelphia

Nov. 15, 1919, **26**, No. 2

Hypophysis Cerebri of California Ground Squirrel, Citellus Beechyi (Richardson). H. J. Cooper, Palo Alto, Calif.—p. 185.
Early Histogenesis of Blood in Bufo Halophiphilus Baird and Girard. R. D. Lillie, San Francisco.—p. 209.
Quantitative Studies on Growth of Skeleton of Albino Rat. H. W. Donaldson, Philadelphia.—p. 237.

American Review of Tuberculosis, Baltimore

November, 1919, **3**, No. 9

Larger Field in Tuberculosis. A. K. Krause.—p. 513.
*Influenza and Tuberculosis. M. Fishberg, New York.—p. 532.
Classification of Laryngeal Tuberculosis. J. Dworetzky, Liberty, N. Y.—p. 544.
*Continuous Injection Method in the Treatment of Experimental Tuberculosis. J. H. Lewis and L. M. Dewitt, Chicago.—p. 548.
Fate of Bacteria Introduced into the Upper Air Passages. A. L. Bloomfield, Baltimore.—p. 553.

Influenza and Tuberculosis.—Fishberg believes that influenza has no etiologic relation to tuberculosis and cannot be considered as a reactivator of a dormant lesion. Tuberculosis patients are not unusually susceptible to influenza, nor is the latter disease more severe in them. The pulmonary sequels of influenza are quite generally nontuberculous and do not require tuberculosis treatment.

Treating Experimental Tuberculosis by Continuous Injection Method.—Lewis and Dewitt applied the Woodyatt continuous injection method to the treatment of experimental tuberculosis. Various concentrations of methylene blue, between 1:500 and 1:3,000, were used. On rabbits the local toxic action of the drug was disastrous, while dogs treated for six hours with 0.2 c.c. per kg. body weight per minute of a 1:500 solution usually died in twenty-four hours. The blood of these dogs drawn immediately after the injection inhibited on glycerin agar the growth of the same strain of bovine tubercle bacilli used in the experiments. The authors believe that the continuous injection method is deserving of further consideration and experimentation.

Archives of Internal Medicine, Chicago

Nov. 15, 1919, **24**, No. 5

*Factors Determining Relative Intensity of Heart Sounds in Different Auscultation Areas. C. J. Wiggers, Cleveland.—p. 471.
Prolongation of "S-T" Interval of Ventricular Complex as Shown by Electrocardiograph. J. Meakins, Montreal, Canada.—p. 488.
*Progressive Lenticular Degeneration Associated with Cirrhosis of Liver (Wilson's Disease). C. P. Howard and C. E. Royce, Iowa City.—p. 497.
*Energy Index (S. D. R. Index) of Circulatory System. J. H. Barach, Pittsburgh.—p. 509.
*Meningococcus Meningitis at Camp Lee. R. L. Haden, Detroit. —p. 514.
*Cholesterol Content of Blood in Various Hepatic Conditions. M. A. Rothschild and J. Feben, New York.—p. 520.
*Three Cases of "Renal Glycosuria." F. M. Allen, M. B. Wishart and L. M. Smith, Lakewood, N. J.—p. 523.
*Type I Pneumonia at Camp Upton; Serum Therapy. C. F. Tenney, Toledo, and W. T. Rivenburgh, Highland, N. Y.—p. 545.
*Determination of Hemoglobin by Acid Hematin Method. L. Berman, New York.—p. 553.
Renal Concentration Power for Uric Acid in Early Chronic Interstitial Nephritis. R. Upham and H. A. Higley, Brooklyn.—p. 557.
*Roentgenographic Studies in Gout. C. W. McClure and E. D. McCarty, Boston.—p. 563.

Intensity of Heart Sounds.—In this study the heart sounds over the apex region, aortic and pulmonary areas were recorded simultaneously or in pairs by the direct sound recording capsules described by Dean and Wiggers. It was found that the intensity of the first sound is not related to the volume of blood discharged by the ventricles, e. g., during slowing of the heart, when the systolic discharge is increased, the first sound is reduced in intensity. The intensity of the first sound over all regions varies directly as the systolic tension developed within the ventricles and with the tension developed during the isometric period of systole. The intensity of the second sound increases or decreases as the pressure (aortic or pulmonary) at the beginning of diastole. When the pressures at the beginning and end of systole increase, particularly in one circuit and relatively little in the other, an accentuation occurs, predominantly in the sounds referred to the circuit in which the changes predominate. In circulatory conditions where the pressures at the beginning and end of systole vary in opposite directions in the greater and lesser circuits, the intensity of the pulmonary and aortic sounds changes in opposite directions. Direct experimental evidence supplements the anatomic basis for believing that sounds heard over the second left intercostal space are transmitted from the right heart and lesser circuit, while those heard over the right second intercostal space and apex have their origin in the left heart and greater circulation. When reserve and caution are exercised, a change in the intensity of the first sound over any area is good evidence of a change in tension developed during systole of the ventricles, while a change in the intensity of the second sound over the aortic and pulmonary areas may safely be used as an index of a change of pressure at the beginning of diastole in the greater and lesser circuits, respectively.

Wilson's Disease.—The anatomic diagnosis in the case cited by Howard and Royce was: cystic degeneration of the basal ganglia; cirrhosis of the liver, colloid cystic degeneration of the parathyroid glands; bacteremia; uniform congestion of the lungs. The histologic diagnosis was: progressive degeneration of the neuron and glial elements of the basal ganglia, most extensive in the lenticular nucleus but involving the optic thalamus, caudate nucleus, internal capsule and red nucleus and, to a slight extent, the white matter just beneath the gray matter of the cortex; chronic interstitial hepatitis; lymphoid hyperplasia manifest in spleen and retroperitoneal lymph nodes; acute congestion of spleen and kidneys; colloid cystci degeneration of the parathyroid glands. A later more careful examination of the brain, after it had been hardened in liquor formaldehydi, disclosed the changes in the lenticular nuclei characteristic of Wilson's disease, a bilateral symmetrical cavitation and atrophy. The cavitation is not sharply confined to the lenticular nucleus itself, but involves, although to a lesser degree, the internal capsule and optic thalamus on both sides. There is a slight grayish discoloration of the globus pallidus.

Energy Index.—The S. D. R. index as a guide to abnormalities in function of the cardiovascular system in a series of 26,396 cases examined by Barach was correct in 99.95 per cent. In cases referred for special cardiovascular examination, i. e., in the clinically doubtful case, the S. D. R. index proved a correct guide in 78 per cent. Of the 22 per cent. in which the index failed, more than three fourths of the cases were tachycardias. The index does not indicate "heart disease" or "decompensation" or "physical fitness." It designates the amount of effort which the circulatory system is putting forth at the time. A high index means increased cardiovascular effort, either the action of the heart and blood vessels is accelerated because of inability to accomplish their work at a normal rate of activity, or they are fully capable of doing their work, but the resistance to their functioning is great. Either condition is pathologic, and the variation of the index from the normal calls attetnion to this. A low index means either that the circulation is accomplished with little effort or an inability to expend the necessary effort. Minor changes in the circulation, such as are produced by the slightest alteration in the bodily functions, the effect of drugs, etc., may be detected by the S. D. R. index.

Meningococcus Meningitis.—Of thirty-one cases of meningococcus meningitis studied by Haden, twenty-one, or 67.7 per cent., showed unmistakable evidence of a generalized infection before there was a localization in the meninges. The mortality of the entire series was 22.6 per cent. During the period of intraspinal treatment alone, and combined intraspinal and intrasubcutaneous treatment, the mortality was 37.5 per cent.; during the period in which intraspinal and intravenous therapy was employed, the mortality was 6.6 per cent. One case is reported in which an active localized infection in the meninges recovered under intravenous therapy alone.

Cholesterol in Blood in Jaundice.—In cases of obstructive icterus due to cholelithiasis, the authors have almost invariably encountered a hypercholesterinemia of a rather severe grade. The degree of jaundice bore a definite relation to the amount of cholesterol in the blood, indicating that this cholesterinemia is due to the obstruction of the bile duct. However, an occasional exception was encountered. In other conditions associated with icterus, such as cirrhosis of the liver, acute yellow atrophy, pernicious vomiting of pregnancy, etc., the cholesterinemia bears no relation to the intensity of the icterus. These facts suggest that in severe disturbances of hepatic function, there is a selective retention of bile pigments, while the cholesterol is not retained. In one case the bile was obtained at necropsy, and showed a rather high content of cholesterol, 0.12 per cent., against a normal content of 0.08 per cent. In other conditions associated with icterus, such as primary or secondary carcinoma of the liver, or multiple abscesses, as seen in polyphlebitis, the cholesterol content of the blood is not proportionate to the intensity of the jaundice.

Renal Glycosuria.—The observation of three cases of renal glycosuria, as compared with thirty-seven cases of true diabetes, and the increasing number of reports in the literature as blood sugar analyses are more employed, the authors believe indicates that "renal" glycosuria is not as rare as was once supposed, and probably is much commoner than other anomalies, such as pentosuria or levulosuria. The etiology was unknown in two cases. In one case severe trauma was either the primary or, at least, the exciting cause. There was no indication of nephritis or renal abnormality in any one of the three cases, except a slightly subnormal phenolsulphonephthalein elimination. The excreted substance in one of the three cases seemed to be an unknown sugar, distingnished from glucose by the absence or incompleteness of fermentation. This may be the most important observation of the present study, and suggests the desirability of closer examination of the fresh urine in such cases for accurate identification of the sugar.

Serotherapy of Pneumonia.—In sixty-one cases Tenney and Rivenburgh injected 100 c.c. of autogenous serum intravenously at eight-hour intervals, day and night, until the rectal temperature registered 100 F. or lower, or evidence of complications or impending death made it advisable to stop the treatment. Thirty patients recovered by crisis, twenty-two by lysis and nine died, a mortality of 14.7 per cent.

Hemoglobin Determination.—A rapid, accurate determination of hemoglobin is made by Berman with the acid hematin method. The blood is obtained with a carefully calibrated pipet, preferably when the patient has not yet had the first meal of the day. It is diluted with tenth normal hydrochloric acid and a reading is made at the end of one minute. Then the fluid in the calibrated tube is carefully boiled over the free flame for one minute. After permitting it to cool for one minute, it is again diluted with tenth normal hydrochloric acid and a final reading is made. A standard similarly constructed with a known normal blood should be used, and be made freshly daily to avoid error due to fading.

Roentgenograms of Gout.—A detailed report of the roentgenographic findings in nine cases of gout is made by McClure and McCarty. All the patients had tophi from which sodium urate crystals were obtained. One case which was clinically not gout is described for purposes of comparison. The findings obtained show that a type of arthritis may occur in gout which presents an unusual appearance in the roentgenogram. Nevertheless, roentgenographic findings in even the most characteristic type of gouty arthritis may be resembled so closely by nongouty arthritis that such findings cannot be considered as more than suggestive of the diagnosis of gout. The focal areas of decreased density in the roentgenogram which roentgenographers consider to be due to tophi, according to the authors, are probably very often merely focal areas of absorption of lime salts. These focal areas are found in from 10 to 12 per cent. of the nongouty arthritides and are, therefore, not diagnostic of gout. Their absence is of more diagnostic value than their presence, since they are almost invariably found in some of the bones of the wrists, hands, ankles or feet in true gout.

Boston Medical and Surgical Journal

Dec. 4, 1919, **181**, No. 23

*Adequate Reduction and Care in Colles' Fracture. New Methods. F. J. Cotton, Boston.—p. 651.
Pathology of Conscience. A. Myerson, Boston.—p. 656.
Low Arterial Tension, etc. G. V. Dearborn, Cambridge, Mass.—p. 659.
*Scarlet Fever Wave in 1919. S. H. Osborn, Boston.—p. 663.
Clinical Picture of Pneumonia in a Boy Aged Two Years Who Subsequently Passed Three Hundred and Seventy Round Worms. W. W. McKibben, Worcester.—p. 665.

Adequate Reduction and Care in Colles' Fracture.—Cotton's method consists in, first, traction and rocking, with the hand a little extended (backward) so as to free the displaced radial fragment and the dislocated ulna; then, with the thumb under the ulna, making it a fixed fulcrum, drag the hand down into flexion and pronation, keeping up traction combined with this flexion and rotation. Flexion is best held in plaster, preferably applied as strip-splints of eight to ten layers of plaster of Paris, bandage, one on the back, from elbow to finger knuckles, one in front, from upper forearm to palm. These are caught with a few turns of plaster-of-Paris bandage. Splinting of three weeks' duration is enough and, from the time of reduction, splints should never immobilize the fingers.

Scarlet Fever Wave in 1919.—Osborn urges that quarantine of the scarlet fever patient should be carried out for twenty-eight days from the onset of the disease and thereafter until infective discharges from the nose, throat, ear and abscesses have ceased.

Florida Medical Association Journal, St. Augustine and Jacksonville

November, 1919, **6**, No. 5

Experiences of an Orthopedic Surgeon at a Port of Embarkation. J. W. Alsobrook, Plant City.—p. 94.

Medical Record, New York

Oct. 18, 1919, **96**, No. 16

*Influenza, with Special Reference to the Pandemic of 1918. J. R. Hurley, U. S. P. H. Service.—p. 651.
Treatment of Peripheral Nerve Injuries. W. W. Babcock and I. J. Spear, U. S. Army.—p. 664.
*Repudiation of Materia Medica and Therapeutics in Modern Medical Teaching. S. L. Dawes, New York.—p. 667.

Influenza.—A review of the literature on influenza leads Hurley to the belief that mixed bacterial vaccines, including streptococci and pneumococci isolated from fresh cases, are useful and worthy of trial in the prophylaxis of the disease, and that the results derived from wearing gauze face masks, particularly those made of three-ply buttercloth, are such as to justify their use as a preventive measure not only by those in direct contact with the sick, but by all persons, mandatorily, during the presence of an influenza epidemic. However, the gauze face mask should not be depended on as a sole protection, but as an adjuvant to all other measures of prophylaxis.

Repudiation of Materia Medica and Therapeutics in Modern Medical Teaching.—The practical abandonment of the teaching of materia medica and therapeutics in the medical schools is regarded by Dawes as being a grave and serious defect in modern medical educational methods. He says that the pendulum has swung far, indeed, from the day when a knowledge of drugs and the treatment of symptoms occupied first place in the curriculum, from the period of polypharmacy and "shotgun prescriptions," so far that it may soon commence a backward movement to stop ultimately in a middle zone.

New York Medical Journal

Oct. 25, 1919, **110**, No. 17

Some Theories of Syphilis. J. Wittenberg, Brooklyn.—p. 669.
Health Classes for Children. I. S. Wile, New York.—p. 675.
Surgical Shock; Its Relation to Anesthesia. A. H. Miller, Providence.—p. 681.

*A Home for Aged and Infirm Physicians. W. Freudenthal, New York.—p. 683.
Rupture of Membranes Fifty Days Before Labor. H. R. Coston, Birmingham, Ala.—p. 683.

Home for Destitute Physicians.—Freudenthal is convinced that destitution among physicians is rather common, and he would have a home for all such unfortunates. A society with that end in view has already been formed, and will soon be incorporated under the laws of New York state. It is Freudenthal's idea to raise a fund of $100,000 and purchase a big tract of land somewhere. The physicians' home should be opened to three classes of physicians (and their wives): (1) those who are able and willing to pay all that is necessary in exchange for congenial surroundings; (2) those who have only a limited amount of money; (3) those who have no means whatsoever.

Nov. 8, 1919, **110**, No. 19

Potential and Acquired Static Flat Foot. E. H. Ochsner, Chicago.—p. 745.
Primary Causes and Hygienic Treatment of Constipation. D. H. Murray, Syracuse, N. Y.—p. 751.
Elastic Closure and Systematic Paraffin Gravity Drainage for Clean and Infected Wounds. A. L. Soresi, New York.—p. 753.
Spectroscopic Alterations in Hemoglobin from Inhalation of Poison Gas. A. Dare, Philadelphia.—p. 755.
Some Phases of Autoerotism. C. P. Oberndorf, New York.—p. 756.
Drug Addiction and Crime. J. A. Hamilton, New York.—p. 760.
Impacted Lower Third Molars. A. M. Nodine, New York.—p. 762.
*Cases of Brain Tumor. E. D. Friedman, New York.—p. 765.
Early Syphilitic Phlebitis. C. G. Cumston, Geneva, Switzerland.—p. 766.

Cases of Brain Tumor.—In one of Friedman's cases the necropsy disclosed miliary tuberculosis and a large solitary tubercle in the pons. In the second case a perithelioma was found in the left parietal region. The hypophysis was enlarged to twice its normal size, due to diffuse adenomatous hypertrophy.

Nov. 15, 1919, **110**, No. 20

Significance of Vascular Changes in Socalled Pandemic Influenza. D. Symmers, New York.—p. 789.
Studies in Paraphrenia. A. A. Brill, New York.—p. 792.
Large Spindle Cell Sarcoma of Rectum. J. F. Saphir, New York.—p. 798.
Group Practice of Medicine. M. Schulman, New York.—p. 800.
*Pathology and Bacteriology of Bronchopneumonia in France. M. L. Morris, New York.—p. 802.
Urethral Stricture. C. O. Files, Portland, Me.—p. 804.
Study of Degeneracy as Seen Among Morphin Addicts. C. B. Pearson, Catonsville, Md.—p. 805.
Study of Necropsy Records. C. B. S. Gibbs, Syracuse.—p. 808.
Splenorenal Theory of Paroxysmal Hemoglobinuria. C. G. Cumston, Geneva, Switzerland.—p. 812.

Pathology and Bacteriology of Bronchopneumonia.—The observations reported on by Morris were made in 175 cases of bronchopneumonia coming to necropsy. The right upper lobe was involved 150 times, the right middle lobe, 130 times; the right lower lobe, 165 times; the left upper lobe, 157 times; the left lower lobe, 166 times. Jaundice was present in 49 cases; acute splenic tumor, in 25 cases; empyema, in 9 cases; pericarditis, in 7 cases; acute toxic gastritis, in 93 cases; acute endocarditis, in 3 cases. The most striking features were: involvement in a majority of the cases of all of the lobes, with the lower lobes involved most frequently, and the right middle lobe the least frequently; absence of splenic tumor; presence of acute toxic gastritis; during life the absence of hyperluekocytosis and the presence of a high polymorphonuclear differential count. The blood culture was negative during life.

Oklahoma State Medical Ass'n Journal, Muskogee

November, 1919, **12**, No. 11

*Pneumonia. W. W. Rucks, Oklahoma City.—p. 303.
Surgical Complications of Pneumonia with Special Reference to Empyema. A. L. Blesh, Oklahoma City.—p. 307.
*Etiology and Pathology of Spanish Influenza. L. A. Turley, Norman.—p. 311.
Some Sequels of Epidemic Influenza. A. B. Leeds, Chickasha.—p. 318.
Prevention of Influenza and Allied Diseases. W. F. Dutton, Tulsa.—p. 321.
Two Cases of Traumatic Asphyxia. E. S. Clinton, Tulsa.—p. 330.

Glucose in Pneumonia.—Rucks says that at Fort Sam Houston Base Hospital they gave 250 c.c. of a 10 per cent. solution of glucose intravenously in the pneumonia cases with good results. The acidosis suggested its use and the results were that, after its administration, several hours of quiet rest ensued, the cyanosis was diminished, the evidence of edema lessened, the heart strengthened and elimination increased. To avoid the chill that sometimes followed they almost habitually added one-eighth grain morphin to the solution; also if digitalis was indicated it was added.

Etiology and Pathology of Spanish Influenza.—On the basis of his postmortem observations Turley feels justified in holding the belief that there is a separate disease entity commonly called the Spanish influenza, but which is more properly a hemorrhagic pulmonitis or a pulmonary phlebitis. He thinks the infective etiologic factor is most probably a very minute ultramicroscopic organism, possibly *Streptococcus pandemicus* or the filtrable micrococcus of the English investigators. The characteristic lesions are in the vascular system of the lungs rather than in the parenchyma of those organs, and the picture seen at necropsy can best be explained on this basis.

South Carolina Medical Ass'n Journal, Greenville

November, 1919, **15**, No. 11

Examination of Heart in Health and Disease. J. B. Townsend, Anderson.—p. 614.
Treatment of Hypertrophy of Prostate in Three Stages for Borderline Case. C. A. Mobley, Orangeburg.—p. 617.
Diarrhea Originating in Faulty Gastric Functioning. G. M. Niles, Atlanta.—p. 620.

Southern Medical Journal, Birmingham, Ala.

November, 1919, **12**, No. 11

An Alphabet of Abdominal Diagnosis. S. R. Roberts, Atlanta.—p. 655.
*Relation of Endothelium to Purpuras, Angioneurotic Edemas and Allied Disturbances. E. C. Thrash, Atlanta.—p. 660.
History Taking. G. Wilson, Baltimore.—p. 662.
Present Status of Wassermann Reaction. L. C. Todd, Charlotte, N. C.—p. 667.
Gastric-Intestinal Disturbances Seen on Western Front. E. R. Gordon, McComb, Miss.—p. 670.
Administrative and Educational Phases of Control of Venereal Diseases. C. A. Abele, Jackson, Miss.—p. 674.
Diagnosis of Tuberculosis of Kidney. D. N. Eisendrath, Chicago.—p. 679.
Treatment of Ureteral and Renal Stone. O. S. McCown, Memphis.—p. 686.
*Anomaly of Kidney. B. N. Dunavant, Memphis.—p. 689.
Case of Uterus Didelphys with Hematocolpos in an Atresic Lateral Vagina. R. A. Bartholomew, Atlanta.—p. 691.
Early Diagnosis of Biliary Tract Infection. E. Schisler, St. Louis.—p. 694.
Changes in Surgical Treatment of Pleural Empyema Following Recent Epidemic of Pneumonia. A. W. Ralls, Gadsden, Ala.—p. 697.
Treatment of Gunshot Fractures of Extremities. R. F. Mason, Memphis.—p. 700.
Pre-Operative and Postoperative Treatment. R. M. Harbin, Rome, Ga.—p. 702.
Suprapubic Prostatectomy. J. A. Graham, Chicago.—p. 707.

Vessel Endothelium and Hemorrhage.—Thrash believes that so-called idiopathic capillary hemorrhages, purpuras, angioneurotic edemas, petechial hemorrhages, all result from the changing from flattened tube-forming structures to mitotic globular cells for the purpose of defending the economy against an invading enemy in the form of chemical, bacterial, animal or endogenous poisons, and in this way disintegrating the capillaries, arterioles and venules, leaving them in such a state that through their walls serum may transude to produce edema, red cells may pass out by diapedesis to produce purpura and from their ends blood may flow to produce frank hemorrhage.

Anomaly of Kidney.—Dunavant reports a case of complete fusion of the right and left kidney, found in a patient operated on for fibroids of the uterus. On a level with, and to the right of, the promonotory of the sacrum, was a rounded mass about 3 inches in diameter, retroperitoneal and below the bifurcation of the aorta, which was displaced upward. Examination of the right and left kidney fossa revealed an absence of the kidney from its normal bed on each side. The peritoneum was incised over the kidney mass revealing a typical renal fatty capsule and characteristic color and appearance of kidney substance. No further investigation of the kidney was made, as there was nothing in the history or appearance to indicate the pressure of a pathologic condition in it.

Texas State Journal of Medicine, Fort Worth

November, 1919, **15**, No. 7

Medical Campaign of Division of Venereal Diseases of U. S. P. H. S. R. Blue, Washington, D. C.—p. 241.
The El Paso (Texas) Venereal Clinic. B. W. Wright, El Paso. —p. 242.
Venereal Problem: What Have We Accomplished? S. J. Wilson, Fort Worth.—p. 245.
Venereal Diseases and the Public Health. C. H. Sanders, Fort Worth. —p. 246.
Venereal Disease Control. H. C. Hall, Austin, Texas.—p. 250.
*Treatment of Gonorrhea in Women. B. W. Turner, Houston.—p. 253.

Treatment of Gonorrhea in Women.—Turner prescribes home treatment and office treatment in these cases. The former consists of douching and tamponing. At first he prescribes picric acid douches, two daily (teaspoonful of powdered picric acid, dissolved in 2 quarts of hot water, to be given only in the recumbent position and with care). Then a 5 per cent. protargol vaginal cone is so inserted as to rest against a tampon previously inserted. A 5 to 10 per cent. protargol ointment is applied to the vulva, covering the urethra, labia and parts. A well fitting soft pad is applied and worn constantly. The office treatment is applied three times daily. The vulva is carefully washed with mercuric chlorid solution, the patient is cauterized, the bladder drained and at least 4 drams of solution (a 25 per cent. argyrol or 1 per cent. protargol) is instilled into the bladder. A vaginal speculum is inserted and if the cervix is not involved a large woolen tampon, dipped in glycerin and coated with argyrol crystals, is applied directly to the cervix. If the cervix is involved, a large cotton applicator is applied to the cervix to remove the mucous sheets about the part. If this does not readily come away a soda solution is used to remove it. Tincture of iodin is applied cautiously to the external os and a small amount inserted in the orifice with a small applicator. The glycerin and argyrol tampon is applied snugly to the cervix. Argyrol crystals are applied to the vaginal wall external to the tampon, the parts are greased with protargol ointment and the vulva pad is applied.

In cases of chronic gonorrhea Turner orders the following douche:

℞		Gm. or C.c.	
	Phenol		
	Zinc sulphate ..... āā	16	ʒ iv
	Powdered alum	30	ʒ i
	Oil of peppermint	6	ʒ iss
	Boracic acid ..... q. s. ad.	120	ʒ iv

Sig.: Teaspoonful to each quart of water, as a douche.

This is alternated every day, with increasing strength of silver nitrate as a stimulating douche (from 1:1,000 to 1:500). Tincture of iodin, 1 dram to the quart of water, is also excellent when a douche to relieve soreness is required. The vaginal cones are increased in strength until they reach 10 per cent. protargol.

Virginia Medical Monthly, Richmond

November, 1919, **46**, No. 8

Problems of Public Health. E. G. Williams, Richmond.—p. 191.
Science and Practice of Internal Medicine. H. A. Christian, Boston. —p. 196.
Semicentennial History of Medical Society of Virginia. J. N. Upshur, Richmond.—p. 201.
Student Nurse. W. A. Baker, Big Stone Gap, Va.—p. 208.
Intussusception in Nineteen Months Old Child. O. K. Phlegar, Graham, Va.—p. 209.

Wisconsin Medical Journal, Milwaukee

November, 1919, **18**, No. 6

Care of Wounded in Zone of Advance and on Front Lines. G. E. Seaman, Milwaukee.—p. 193.
Prolapse of Uterus; Its Surgical Treatment. W. E. Fairfield, Green Bay.—p. 206.
Indications for Davis Cesarean Section. R. W. Roethke, Milwaukee. —p. 212.
*Experimental Treatment of Fractures by Use of Plates. R. F. Fisher, Wausau, Wis.—p. 215.

Experimental Treatment of Fractures.—The object of Fisher's experimental work was to study the operative treatment of fractures by the use of steel plates. There were twenty-two experiments done on dogs, using the Lane plates, and four experiments in which small pieces of ivory, cow's bone and dog's bone were used. Briefly, the results have shown that if operative treatment for malunion of a fracture is required, bone grafting, though more difficult, usually gives better end results than the use of a steel plate.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Children's Diseases, London

July-September, 1919, **16**, Nos. 187-189

A Visit to Germany. J. Addams and A. Hamilton.—p. 129.
*Etiology, Prevention and Nonoperative Treatment of Adenoids. H. Campbell.—p. 140.
*Alveolar Sarcoma with Metastases in Skull. E. Cautley.—p. 144.
Case of Chorea Complicated by Gangrene of Fingers. H. H. Chodak. —p. 148.
*Case of Multiple Epulides. W. W. James.—p. 151.

Dietetic Treatment of Adenoids.—Campbell claims that faulty intestinal digestion causes adenoids. The chief fault lies with cereal foods, which are consumed in a spongy, pappy, and pultaceous form. We eat too much spongy (noncrusty) bread and pultaceous pudding, and too little raw vegetable food in the shape of salads and fruit. As a result of this kind of diet the maxillary apparatus (including the nasal passages, nasopharynx and salivary glands) does not develop properly; the local flow of blood and lymph is not adequately stimulated; starchy foods do not undergo adequate salivary digestion; and an excess of wholly nondigested starch (as well as of sugar) passes into the bowel, there to give rise to indigestion and putrefaction (as shown by the malodorous motions). Then follow toxemia, malnutrition, diminished resistance to infection catarrh, and adenoids.

Abdominal Sarcoma with Metastases in Skull.—In Cautley's case the primary tumor was situated in the lumbar region. Between the two kidneys and in the middle line there was a bilateral growth as big as a small orange, firmly adherent to the periosteum of the spine, and compressing the kidneys, more especially the left one. The growth extended along the spinal column downward and branched off into each iliac fossa, where large nodules were formed in connection with the periosteum. The inguinal glands were enlarged. In color the growth was dirty blue, and in consistency spongy in parts. Microscopically it proved an alveolar sarcoma.

Case of Multiple Epulides.—James' patient, a girl, aged 11 years, suffered from the growth of a fibrous epulis associated with each tooth of the temporary and permanent series which had erupted. Removal of the growth alone was followed by recurrence, which does not take place when the teeth are also removed. Up to the present all the temporary and eight of the permanent teeth have been extracted.

British Medical Journal, London

Nov. 22, 1919, **2**, No. 3073

*Normal and Morbid Conditions of Testes from Birth to Old Age in One Hundred Asylum and Hospital Cases. F. W. Mott.—p. 655. To be cont'd.
Cancer. J. R. Morison.—p. 659.
*Enlargement of Thyroid in Malaria. J. B. Hume.—p. 661.
Studies on Acute Nephritis. K. Petren.—p. 663.
Treatment of Tuberculous Cripple at Hospital for Children, Leasowe. T. H. Martin.—p. 664.
Superimposition of a Retrograde on a Direct Intussusception in Child Aged Two Years. J. P. Buckley.—p. 665.
Kala-Azar in Mesopotamia and Its Incubation Period. C. A. Sprawson.—p. 667.

Pathologic Changes in Testes in Mental Diseases.—Macroscopically, sections of fresh or hardened testes revealed pathologic changes in a majority of the asylum cases studied by Mott; the converse was noticeable in the adult hospital cases. In the asylum cases the most marked deviation from the normal condition was found in two groups of cases, namely, (1) general paralysis, (2) dementia praecox. There was no correlation between the macroscopic cortical changes in the brain in general paralysis and the morbid changes in the testes. As a general rule, the degree of morbid macro-

scopic change of the testes in dementia praecox conformed to the duration of the mental disease and the clinical signs and symptoms of the mental decadence rather than to any obvious macroscopic changes or defects in the brain. In general paralysis, the dementia corresponds in great measure to the degree of cortical destruction; nevertheless, there is no correlation in this disease between the brain atrophy and the testicular atrophy. With the exception of cases of senile dementia and congenital imbecility with epilepsy, the testes in other fatal asylum cases did not, as a rule, show any marked departure from the normal, for example, cases of epileptic insanity, Korsakoff psychosis, paranoia and manic depressive insanity.

Enlargement of Thyroid in Malaria.—Although the frequency of occurrence of marked thyroid enlargement noted by Hume is probably not greater than from 5 to 10 per cent. —the cases with some very slight temporary enlargement immediately after an attack of malaria might probably represent an additional 10 per cent.—he is inclined to believe that the changes in the ductless glands in malaria may be far more marked than present knowledge shows. These changes may be due to sporulation of the parasites in the capillaries of the gland, analogous to the condition in cerebral malaria. This would cut off the supply of iodothyrin from the blood stream, and upset "thyroid equilibrium." To regain this, compensatory hypertrophy takes place, and equilibrium is regained in the course of time. The remaining thyroid swelling becomes purely a hyperplaisa; or there is a compensatory hypertrophy of the other ductless glands. On the other hand, enlargement of the thyroid may be compensatory for the exhaustion of other parts of the endocrine system. Degenerative changes have been described in the suprarenals in malaria; and disturbance of these glands may be the cause of the "algid type" of malaria, which, clinically, injections of epinephrin are most valuable in combating. The low blood pressure, and the subnormal temperature, which often lasts for days after an attack, both indicate a condition of hypo-adrenia. The loss of sexual power frequently observed after attacks of both treated and untreated malaria is likely also to be due to the effect of the disease on the testes.

Lancet, London

Nov. 22, 1919, **2**, No. 5021

Voluntary Muscular Movements in Cases of Nerve Injuries. F. W. Jones.—p. 907.
*Methods of Choice in Immunity. A. G. Shera.—p. 909.
Epileptiform Convulsions. R. G. Gordon.—p. 914.
*Treatment of Lupus Vulgaris. R. W. MacKenna.—p. 917.
Causes of Disease and Death in the Antenatal Period. G. Davison. —p. 919.
*Case of Wernig-Hoffmann Type of Progressive Spinal Muscular Atrophy. E. A. Barton, and H. Ingleby.—p. 922.
*Case of Extreme Esophagectasia. H. B. Shaw.—p. 923.

Methods of Choice in Immunity.—In this paper Shera discusses this axiom: Against an exotoxin a serum should be employed; against an endotoxin a vaccine should be used. Against a combination of both exotoxin and endotoxin both a serum and a vaccine should be used, as bearing on the treatment of streptococcus infections.

Treatment of Lupus Vulgaris.—In McKenna's opinion the method *par excellence* for the treatment of lupus affecting the mucous membranes, either of the nose or mouth, is cauterization with the electrocautery. To use this method effectively, it is advisable to make a series of punctures all over the affected mucous membrane at short distances from one another.

Werdnig-Hoffmann Paralysis.—The case cited by Barton and Ingleby differs from those previously recorded in that nystagmus was a pronounced symptom and was probably due to the morbid condition of the oculomotor nucleus; also there was profuse sweating almost from the first. A complete postmortem report is given.

Case of Extreme Esophagectasia.—Shaw claims that on the basis of five symptoms a diagnosis can be made in this condition without the aid of the roentgen ray: 1. The taking of solid food causes pain at the epigastrium; (2) this pain is accompanied by what the patient calls vomiting, but is really regurgitation of food; (3) the act of taking the solid food soon provokes a cough; (4) it sometimes happens that the patient becomes breathless, and this is particularly so after attempting to take more solid food than usual; (5) liquid food causes none of these symptoms.

Archives Médicales Belges, Liége

June, 1919, **72**, No. 6

*Research on Cyclopean Microphthalmos. G. Van Duyse.—p. 625. Conc'n in No. 7, p. 1.
Malaria in Belgium. J. Firket.—p. 660.
*Stuttering of Endocrine Origin. A. A. da Costa Ferreira.—p. 680.
*Spontaneous Rupture of Varicocele. F. Van den Branden.—p. 683.
The Transmissible Diseases in 1918. M. Stassen.—p. 723.
Diagnosis and Treatment of Pithiatic Paralysis. R. Marchal.—p. 730.

Cyclopean Eye.—Van Duyse's study of a cyclopean single eye throws light, he says, on the pathologic anatomy and pathogenesis of such malformations and on the embryology of the eye in general.

Stuttering an Endocrine Disturbance.—Da Costa's clinical experience at Lisbon has revealed morphologic, physiologic and psychologic evidence that stuttering is only one manifestation of a general endocrine disturbance, which the physician is often able to modify and thus cure the stuttering. He here reports the pulse findings in two stutterers which reveal that there is a tendency to a neurosis of the sympathetic system. This is presumably of endocrine origin, and, most probably, the thyroid is primarily responsible.

Spontaneous Rupture of a Varicocele.—Van den Branden relates that the young man was shaving when he suddenly experienced such pain in the scrotum that he swooned, and the operation two days later showed a hematocele. There were no traces of venereal disease, but treatment had been given eight years before for acute varicocele. Palet's compilation lists only five cases of spontaneous rupture, and these were all in elderly men.

Archives de Médecine des Enfants, Paris

November, 1919, **22**, No. 11

*Tardy Scurvy in Children. E. Weill and A. Dufourt.—p. 561.
*Diabetes Mellitus in Children. P. Nobécourt.—p. 573.
Organized Surveillance of the Health of Children. P. F. Armand-Delille.—p. 587.
*Multiple Relapsing Phlebitis. A. Roux.—p. 593.
Mongolian Blue Spot in Brazil. C. Ferreira. (S. Paulo).—p. 597.

Deficiency Diseases in Children.—Weill and Dufourt relate that nine cases of scurvy developed in a group of children from 2½ to 6 years old recently repatriated from the regions occupied by the Germans. Enteritis and dysentery had been diagnosed, and although the gingivitis was extreme and painful, and the children cried day and night, the true diagnosis was not suspected. The enteritis had lasted from three to ten months in some of the children, and fruit and green vegetables had been dropped completely, as tending to aggravate the bowel disturbances. Weill changed all this at once, and had the gums painted with lemon juice. The prompt improvement when the antiscurvy diet was given soon convinced the most skeptical. All the children were completely cured within a month.

Diabetes Mellitus in Children.—Nobécourt reports a case in which diabetes mellitus developed in a girl of 11½. Although the glycosuria was pronounced and it proved impossible to reduce it, the general health had kept comparatively good during the seven months, except that the child was backward in her growth. On an antidiabetic diet, signs of acidosis became apparent, and she was then allowed to eat the ordinary hospital food, with 50 gm. of sugar in addition, and under this the diacetic acid content of the urine grew less. When sugar was suppressed, the signs of acidosis returned, but they subsided anew when the sugar was resumed. It had thus a distinctly favorable action in this case. The dietetic restrictions cannot be as severe for children as for adults. The outlook is always grave with this form of diabetes in children; he describes two cases in which the girl of 15 and boy of 9 died in coma two months and thirteen months after the first symptoms, the coma coming on after a brief period of somnolency. The onset of

coma is generally heralded by the acetone odor of the breath and urine and the acetonuria, but these latter may exist, without coma, as in the case described above. The ferric chlorid test for diacetic acid will reveal it before coma is installed.

Relapsing Phlebitis.—Roux reports the ultimate outcome in a case of relapsing phlebitis he published in 1916. The phlebitis of the inferior vena cava had developed after endocarditis. The infection died down for seventeen months and then flared up again, with phlebitis of the left axillary vein and the sinus cavernosus, and gangrenous cavities in the lungs. Two cases of diabetes in the family suggested a possible constitutional predisposition.

Bulletin de l'Académie de Médecine, Paris

Nov. 11, 1919, **82**, No. 35

*Treatment of Elephantiasis of the Legs. C. Walther.—p. 262.
*The Milk Supply of Paris. H. Martel.—p. 268.
Prophylaxis of Tuberculosis. A. Calmette.—p. 275.
*Obstruction of Bile Duct by Hydatid Vesicles. F. Dévé.—p. 282.
Vaccine Therapy of Meningitis. H. Méry and L. Girard.—p. 284.
*Neolithic Human Races. M. Baudouin.—p. 286.
*Wounds of the Eye. F. Lagrange.—p. 292.

Buried Tube Drainage of Elephantiasis.—Walther has now a record of ten cases of elephantiasis of the legs, treated by introducing a tube for supplementary drainage of lymph from the leg into the abdominal cavity. With a 42 cm. long trocar he tunnels a passage for it from the crural incision to the abdominal incision, and fastens the upper end of the tube to the lip of the buttonhole in the aponeurosis. The patient stays in bed four or five weeks, the leg raised on a cushion and wound with a light bandage renewed daily to induce gentle and regular compression. When the patient is allowed to get up, the thick and sagging skin is massaged and electricity applied, and it may gradually return to its normal elasticity and aspect. In one case the skin by the end of a year of massage and electricity had resumed a completely normal aspect. All still wear an elastic stocking or compressing bandage. There has been no recurrence in from one and a half to three and a half years in those with the longest intervals, and the fine and durable effects have encouraged him to persevere in this method of treating this hitherto almost incurable condition. All but two of his ten patients were women, and he remarks that the only feature of the cases which suggests a bacillary origin is the age at which the elephantiasis began to develop, between 10 and 21 in all but four cases, and up to 32 in these.

The Milk Supply of Paris.—Martel relates that the milk supply of the Paris district has declined to such a point that in October the authorities prohibited the use of fresh milk and fresh cream alone or in beverages in all hotels, cafés, etc., and milk cards have been reintroduced giving priority in the delivery of milk to children and the sick. When the Germans retreated, they drove all the remaining cattle before them into Germany. No cattle of the former fine breeds are left in the occupied zone, and those that have been imported are of inferior breeds or damaged. The milch cows imported from the United States were long detained at the embarking point by strikes, and the cows kept in the mud developed diseases, contagious ophthalmia among others, which was thus introduced and spread by the imported cattle. The treaty of peace calls for return of 600,000 cows from Germany, but very few have been returned to date, and certain pasturing regions have no cows at all. The drought last summer contributed to aggravate conditions, and foot-and-mouth disease is prevalent in a large number of provinces and is spreading. Butter and cheese makers and those raising calves for choice veal use large amounts of milk and pay fancy prices for it. He urges prohibition or at least restriction of the making of cream cheese, and prohibition of the sale of "extra" veal. The calves fattened for this are given 15 or 20 liters of milk a day for months. Before the war, the Paris district received by train about 830,000 liters of milk daily. By November, 1919, the amount received averaged only 430,000 liters. The local production has likewise dropped from 115,000 to 60,000 liters.

Hydatid Vesicles Obstruct Bile Duct.—Dévé operated on a woman of 28 for jaundice that had persisted for over a year, with fluctuating intensity. The expected gallstones were not found, but the seventh day a hydatid vesicle as large as a pigeon's egg was found in the dressings, and five others presented later, the biliary fistula then healing in five weeks. There has been no further trouble during the eight years since. In 176 cases on record of hydatid cyst in the liver emptying into the biliary passages, in fifty-four the obstruction was protracted, from three weeks to a year in the different cases. The débris of the daughter cysts are not recognized in the stools unless the feces are passed through a sieve. Drainage of the common bile duct has sometimes permitted the complete cleaning out of the hydatid cyst in the liver, as in the case here reported. The surgeon had better not rely on this, but operate directly on the pocket in the liver. The symptoms with the jaundice do not differ from those with gallstone obstruction, unless there may be urticaria after an attack of pain, a bulging of the liver at some point, enlargement of the gallbladder, eosinophilia and deviation of complement.

Flat Humerus in Prehistoric Races.—Baudouin discusses what he calls the platybrachia noted in the arms of child skeletons of the polished-stone period. The femur, on the other hand, shows the flattening more in adults than in children. He argues that this proves that man was an absolutely quadruped animal at first.

Wounds of the Eye.—Lagrange shows that the gravity of injury of the eye depends on whether the ciliary region is involved or not. He says that any medical man should be able to enucleate the eye at need. Even when the foreign body is not in the ciliary body, if the eye is somewhat tender, and there is hypotony, and the nutrition is suffering, it should be enucleated, as also when there is old cyclitis with inflammatory reaction resisting appropriate treatment for several months.

Bulletin Médical, Paris

Nov. 1, 1919, **33**, No. 48

*Inoperable Cancer of the Tongue. J. Belot.—p. 641.

Inoperable Cancer of the Tongue.—Belot says to "always operate," but when this is impossible, the roentgen rays and radium afford palliative treatment which is often very useful but sometimes absolutely ineffectual. Radiotherapy may relieve inoperable cancer, but it does not cure. Post-operative exposures seem to augment the chances for extermination of the malignant disease. He has been applying for a long time the Coolidge tube to the raw surface before suturing, after removal of mammary cancer, and the outcome has been perfect. It seems logical to apply this measure also after removal of cancer of the tongue.

Nov. 8, 1919, **33**, No. 49

*Endocrine Insufficiency in Children. L. Tixier.—p. 655.

Nov. 15, 1919, **33**, No. 51

Opening of Otorhinolaryngology Course. P. Sebileau.—p. 679.

Endocrine Insufficiency in Children.—Tixier analyzes in turn the clinical manifestations from insufficiency of the thyroid, suprarenals, pituitary and genital glands, and pluriglandular insufficiency. He says that the minor signs of thyroid insufficiency are comparatively common between 10 and 15. They may include frontal headache or occipital neuralgia, severest in the morning, with lassitude after work and drowsiness after eating, and the children cry easily. The hands are pale or blue, the extremities cold. Thyroid treatment should be accompanied by restriction to a milk and vegetable diet, with a saline purgative once or twice a month. He gives the dry extract, 1 or 2 cg. daily, fractioned, to children under 5. Above this age he gives 5 cg. per day. Between 10 and 15, doses of 0.10 or 0.15 gm. are so high that special medical surveillance is necessary. The parents should take the pulse morning and evening, reclining and standing, and the rectal temperature. If the pulse goes up to 104 or 110 or the temperature goes above 38 C. (100.4 F.) the thyroid treatment should be stopped without waiting for

tremor and other symptoms. In the majority of cases, a few weeks of thyroid treatment abolish temporarily or permanently these minor signs of thyroid insufficiency. It may tone up the thyroid so that a tendency to myxedema may be thrown off. With actual myxedema, the thyroid treatment, he says, should be given twenty days each month throughout life. Treatment of pluriglandular insufficiency does not require strictly specific organ extracts. On account of the synergy of the endocrine glands, one extract may prove effectual when others fail, even when the new organ extract does not seem to have anything to do with the symptoms observed, continuing the treatment possibly for months, and alternating or combining the organ extracts according to the results obtained. If there is any tendency to a positive Wassermann reaction, mercurial or arsenical treatment should supplement the organotherapy. In any event, organotherapy of any kind requires medical surveillance.

Bulletins de la Société Médicale des Hôpitaux, Paris

Oct 24, 1919, **43**, No. 29

*Pleuropulmonary Vasomotor Reactions. D'Oelsnitz and L. Cornil.—p. 861.
*Mixed Meningitis. H. Claude, H. Schaeffer and S. Bernard.—p. 863.
*Shock from Small Transfusion of Blood. L. Boidin and others.—p. 869.
*Syphilitic Meningomyelitis. P. Nicaud.—p. 875.
Case of Typhoid Meningitis. Idem.—p. 877.
*Tardy Jaundice after Arsphenamin. Sicard, Haguenau and Kudelski.—p. 880.
*Different Forms of Nephritis. Hélouin.—p. 889.
*Chloro-Azotemic Nephritis. Hélouin.—p. 893.

Vasomotor Reactions with Lesions in Pleura and Lungs.—D'Oelsnitz and Cornil state that in different pathologic conditions in one side of the chest, the arm on that side shows various vasomotor disturbances. The latter differ with different forms of pleuropulmonary disease. They can be detected best with the oscillometer, and they are evidently due to irritation of the cervical sympathetic. They have been studying these phenomena with epinephrin, amyl nitrite, mechanical, heat and other tests, elastic constriction of the arm, and compression of the eyeball. The findings suggest that oscillometer tests of the corresponding arm may prove a useful diagnostic measure to supplement the routine measures with latent intrathoracic foci.

Mixed Meningitis.—The man of 54 presented the clinical picture of meningococcus meningitis following meningococcemia, with joint lesions. Slight improvement followed serotherapy but it was transient, and tubercle bacilli were cultivated along with the meningococcus from the spinal fluid and from the sylvian region of the brain after death.

Shock After Transfusion of Blood.—Only 40 c.c. of citrated blood had been transfused in treatment of post-typhoid septicemia in the young woman, but an extremely violent shock followed at once, and with convulsions, the sixth day and then coma for four days, with final recovery. The transfusion had been made very cautiously, but the hemoglobinuria testified to the hemolytic action of the transfused blood although no incompatibility between the blood of donor and recipient had been detected in the test tube. This extremely grave reaction to such a small amount of blood transfused with the utmost precision of technic was a painful surprise, but it is possible that this excessively violent albuminoid shock may have turned the scale in favor of recovery in the otherwise fatal septicemia. In conclusion the writers cite Lewisohn's warning against transfusion in very acute septicemia, on account of the alarming reaction which may follow. But they are convinced that the septicemia would have proved fatal without it. The father was the donor.

Syphilitic Meningomyelitis.—Nicaud reports a case of sudden complete flaccid paraplegia, with pronounced sensory disturbances, the tenth year of syphilis. Under neo-arsphenamin recovery was practically complete in three months.

Jaundice and Neo-Arsphenamin.—Sicard and his co-workers present evidence to prove that the drug is responsible for the jaundice that develops during arsphenamin treatment. They have had five instances of it among their 100 cases of chronic syphilitic disease of the nervous system treated by their method of small frequent (every day or every second or third day) intravenous injection of 0.15 gm. of (French) neo-arsphenamin to a total of 30 or 50 injections. The drug was suspended when the jaundice developed in all but one case, and this case was the only one that proved fatal. In two of the five cases the drug was being given for some pathologic condition other than syphilis, there being nothing to suggest either inherited or acquired syphilis. Among the other arguments presented is that the azotemia slowly and progressively increases under the neo-arsphenamin and for some time after its suspension. A further argument is offered by Abatucci's recent cases in which fatal hemorrhages followed a course of neo-arsphenamin, accompanied in one case with jaundice. These symptoms developed six weeks after the course (total dose 8.50 gm. in six weeks at five day intervals). Necropsy revealed acute yellow atrophy of the liver. They denounce Milian's assertion that the syphilis is responsible for the jaundice, and they point to their success with frequent small doses with never any signs of anaphylaxis, as the most reliable and harmless means for administering a given amount of the drug in a given period, far safer than by weekly injections. Milian replied to this by asking them to transfer to his service the next case of what they consider toxic jaundice. He reiterated that with the present technic there is no arsenical toxic jaundice; 95 per cent. of the cases are the work of syphilitic hepatitis roused from slumber by inadequate treatment. The other 5 per cent. are exceptional coincidences, catarrhal jaundice, gallstones, etc.

Different Forms of Nephritis.—Hélouin expatiates on the importance for treatment of an exact diagnosis of the form of the nephritis, and lists nine different types aside from the tuberculous, syphilitic and pyelonephritis forms. He outlines the treatment for each according as the kidney is or is not permeable for chlorids, urea or water.

Chloro-Azotemic Nephritis.—Hélouin applies this term to nephritis in which there is retention of chlorids and urea but not of water. The symptoms are slowly progressive lassitude, lack of appetite, headache, dyspnea on exertion and gastro-intestinal derangement, but no fever or chills. The dyspnea gradually grows permanent, and edema appears. The urine is scanty and contains much albumin but little chlorids or urea, and the blood pressure and the Ambard constant are high. If the patient is allowed nothing but water for a time, all these symptoms subside in the mild cases. In the graver cases, acute pulmonary edema is liable to develop at any moment. It might be brought on by administering salt for the classic test of alimentary chloriduria. Treatment of this type includes venesection and drastic purgatives, restriction to water, and abstention from milk, albuminoids and chlorids. As this form of nephritis improves, the azotemia subsides, but not until the urea content of the blood approximates normal does the chlorid content fall. The chloridemia seems to persist to defend the tissues against the azotemia. The edema persists as long as the retention of chlorids lasts. First the azotemia has to be got out of the way; then the chloridemia subsides, and along with this the edema. If the kidney is damaged too much for complete restitution the Ambard constant and the azotemia figure keep high, and a new wave of azotemia is liable to entail fatal pulmonary edema.

Paris Médical

Nov. 15, 1919, **9**, No. 46

*Inaugural of Otorhinolaryngology Course. P. Sebileau.—p. 385.
*Influenzal Meningitis. G. Rosenthal.—p. 397.

The Otorhinolaryngology Course.—This is the first lecture of the newly founded *Clinique oto-rhino-laryngologique* which has had a long period of gestation since its conception in 1907. A large pavillion at the Lariboisière hospital is devoted to the clinic, and Sebileau expressed his hope that it might attract students from at home and afar and prove not only a center for lively scientific activity, but a *foyer d'amitié confraternelle*.

Influenzal Meningitis.—Rosenthal reports two cases in which recovery followed lumbar puncture with two-way

lavage. It was repeated four times in one case and eight in the other. The fluid is injected through the lumbar puncture needle inside a cannula. The emerging fluid escapes between the needle and the walls of the cannula. By this means there can be no overpressure. He injected 100 or 200 c.c. of plain saline except that for two injections he added 5 c.c. of a 5 per cent. solution of collargol. The fluid was opalescent rather than actually purulent, and no bacteria could be detected in it.

Presse Médicale, Paris

Oct. 29, 1919, **27**, No. 63

*The Triangular Heart. C. Laubry and E. Bordet.—p. 633.
*Snapping Hip Joint. M. Manon.—p. 635.

The Triangular Heart.—Laubry and Bordet conclude from their roentgen study of the heart that it assumes a triangular shape whenever the right ventricle is dilated. The right margin of the ventricle forms a straight line, at an obtuse angle to the diaphragm. They give a number of charts showing the different forms of this triangular heart, and add that persons presenting it must be regarded as *cardiaques* and be treated as such.

Snapping Hip Joint.—Manon describes a case in which the snapping sensation was due to the abnormal tension over the trochanter of a part of the aponeurosis that runs from the fascia lata to the gluteus maximus. It was stretched across it like the strings of a violin over their bridge, and simple transverse section put an end at once to all the disturbance. Local anesthesia enables the mechanism to be studied when the parts are exposed.

Progrès Médical, Paris

Nov. 1, 1919, **34**, No. 44

Masked Epilepsy. R. Benon.—p. 435.
Streptococcus Meningitis; Recovery under Serotherapy. A. Philibert.—p. 437.

Nov. 8, 1919, **34**, No. 45

Chronic Bronchitis. C. Mantoux.—p. 445.
*The Claude Bernard-Horner Syndrome. A. Barbé.—p. 447.
Pneumonia with Recovery under Serotherapy. A. Bernard.—p. 449.

The Claude Bernard-Horner Syndrome.—Barbé describes three cases of this, all consecutive to wounds of the neck.

Gazzetta degli Ospedali e delle Cliniche, Milan

Oct. 2, 1919, **40**, No. 79

Lack of Hygiene in Rural Homes as Factor in Spread of Tuberculosis. P. Giani.—p. 843.

Oct. 5, 1919, **40**, No. 80

Suprarenal Preparations in Epilepsy. T. Silvestri.—p. 852.

Pediatria, Naples

November, 1919, **27**, No. 11

*Nodose Erythema and Tuberculosis. Silvio de Stefano.—p. 705.
*Progressive Ossifying Myositis. A. Drago.—p. 715.
*Pernicious Anemia in Infant. R. Kharina-Marinucci.—p. 734.

Erythema Nodosum and Tuberculosis.—De Stefano tabulates the findings in twenty-three cases of nodose erythema in children from 3 to 12 years old. The tuberculin skin test elicited a positive reaction in every case, exceptionally pronounced in fifteen. The papule that forms in response to the skin tuberculin test seems to be identical in every respect with the nodule of erythema nodosum.

Ossifying Myositis.—Drago reports a typical case of multiple progressive ossifying myositis in a girl of 8 with a positive tuberculin skin reaction. He discusses the nature of the disease and reviews the literature, commenting on the fact that the new forming bone seems to be normal in every respect except its pathologic site in muscle tissue. He queries whether a localized alkalinosis might not be responsible for this, such as Perdue has suggested as a factor in cancer. He tried various treatments in his case without results. The course, he says, is fatally progressive, death generally occurring in consequence of ossification of the vocal cords and esophagus or from tuberculosis secondary to ankylosis of the ribs. Ten or fiftgen years is the extreme range.

Pernicious Anemia in Infant.—In this and in three cases previously published by Kharina-Marinucci, the aplastic pernicious anemia accompanied inherited syphilis; plus tuberculosis in one case. The anemia seemed to be secondary in all.

Policlinico, Rome

Sept. 14, 1919, **26**, No. 37

*Preventive Vaccination against Scarlet Fever. L. Spolverini.—p. 1081.
*Obstruction of Intestines by Clump of Ascarides. G. Aperlo.—p. 1086.

Vaccine Prophylaxis of Scarlet Fever.—Spolverini writes from the children's clinic at Rome to confirm the development of specific antibodies in the serum of children inoculated with antiscarlet fever serovaccine, made according to Di Cristina's technic (described in these columns, March 1, p. 687). He reports further that he constantly obtained a positive response to the deviation of complement test, applied with an alcoholic extract of recently desquamated scarlatinal scales. The ten children given the prophylactic vaccination mingled freely with scarlet fever children, some for as long as two months, and even wore the others' garments sometimes, but none contracted scarlet fever. Their blood showed the constant presence of the antibodies. He ascribes the success of this preventive vaccination to the active immunity conferred by the scales rather than to the passive immunity from the serum from the scarlatinal blood. He is now engaged in research to verify this assumption.

Obstruction of Intestines by Clump of Ascarides.—Aperlo removed a mass of sixty ascarides from the ileus. The intertwined helminths had completely obstructed the bowel in the boy of 7. The loop of bowel was sutured to the abdominal wall for fear it might be necessary to operate again, and this loop ulcerated, so that three months later this segment had to be resected. The ascarides may act by mechanically obstructing the lumen, or by irritating the bowel so that spasm is induced, which closes the lumen likewise.

Sept. 21, 1919, **26**, No. 38

*Hypertonic Solution in Treatment of Certain Bone and Joint Tuberculous Lesions. L. Durante.—p. 1105.

Treatment of Tuberculous Bone Lesions.—Durante has had charge of large numbers of tuberculous soldiers and he here expatiates on the fine results he obtained in 400 cases of cold abscesses. He filled them with a hypertonic solution to induce by osmosis profuse secretion of lymph and attract lymphocytes to the focus. The solution that proved most effectual was a 2.5 per cent. solution of magnesium chlorid in distilled water with 10 drops of liquor formaldehydi per gram, added when cold. He clears out the abscess, rinses and fills the cavity with this solution about every four days, using from 10 to 40 c.c. of the fluid.

Aug. 15, 1919, **26**, Surgical Section No. 8

Modern Treatment of Gunshot Fractures and Wounds of Joints. R. Bompiani.—p. 249. To be cont'd.
*Thrombophlebitis of Sinus Cavernosus. P. Gilberti.—p. 268.
*Bone Complications of Typhoid. Umberto Tassone.—p. 274.

Thrombophlebitis of Sinus Cavernosus.—Gilberti reports the cure after multiple resections in a case of thrombophlebitis in a young soldier. It was evidently secondary to an infectious process on the lip, by way of the facial vein. The exophthalmos, chemosis, edema of the conjunctiva and optic changes in the fundus evidently resulted from the disturbance in the return circulation, but direct nerve damage was responsible for the paralysis of the third, fourth and sixth nerves, and the branch of the ophthalmic nerve that runs in the rear wall of the sinus. The general symptoms were mainly those of pyemia, while headache and slight delirium testified to meningism, and the extreme prostration suggested the typhoid form. In three similar cases he has encountered, two of the patients died in less than two days from the first symptoms. Operative treatment is the only resource, but healing is usually such a slow process that the eye on that side is irrevocably lost, as in the case described. Four operations were required and antistaphylococcus serum was given freely, with local measures First the jugular vein was ligated after aspiration of 80 c.c. of blood, and later the facial vein, and veins in the scalp were resected or incised and cauterized as they showed signs of severe thrombo-

phlebitis. The man was in the hospital for three months. When he left he was in good condition except for the total blindness in that eye. Vision in the other was good.

Bone Complications After Typhoid.—Tassone comments on the predominance of young persons, between 11 and 20, among those that develop bone complications after typhoid. He suggests that the greater liability to bumps and knocks in the young may explain this. The bone complications may be merely pains suggesting rheumatism but terminating in spontaneous resolution, or there may be actual acute or chronic osteoperiostitis, with suppuration, or a chronic form without suppuration, with a tendency to exostosis production. Months and years may pass before the complication develops, and any rise in the temperature after typhoid, especially during convalescence, should suggest the possibility of complicating bone disease. In a case described the young man had lively pains all over his body during convalescence from typhoid. The pains subsided in a few days except in the left ankle where a suppurative process developed. It spread to the knee, and the fistula in the ankle kept suppurating for a month. There was also pain in one ear and discharge for a month. The lids also swelled but returned to normal after two weeks or more, and the left eye was left totally blind. The crippling of the left leg entailed by the long suppurative process was corrected by an operation when the inflammation had entirely subsided. The multiple suppurating foci, the extensive and profound destruction of bone and the hyperplastic tendency thereafter were notable features of this case.

Archivos Españoles de Enf. del Ap. Digestivo, Madrid

October, 1919, **2**, No. 10

*Frequency of Cancerous Degeneration of Gastric Ulcer in Spain. L. Urrutia.—p. 579.
*Determination of Diastase or Amylase in Body Fluids. J. Luis-Yagüe y Espinosa.—p. 586.

Malignant Degeneration of Gastric Ulcer.—Urrutia relates that in 17.7 per cent. of 158 cases of gastric cancer of which he has full records there was a history of stomach disturbances from three to fifty years before the cancer. In 20 per cent. the cancers had the aspect of an ulcer-cancer and 12.5 per cent. of the hard, boring ulcers showed signs of malignant degeneration. His personal experience, therefore, has been that from 15 to 20 per cent. of chronic callous ulcers develop cancer. He cites similar statistics from other countries; they range from Fenwick's 3 per cent. in England, to 80 per cent. at the Mayo Clinic, and 100 per cent. in Zenker's service in Germany.

Determination of Diastase and Amylase in Body Fluids.—Luis-Yagüe gives some tables for ready computation of the amount of amylase in the fluid being examined, and gives directions with which any physician can estimate the approximate content of diastase and amylase in the saliva, urine, blood and feces. He adds to 1 c.c. of the saliva or other fluid being examined from 0.1 to 0.5 c.c. water, using a set of test tubes and then pours in each tube 1 c.c. of a 5 per cent. solution of starch, cooked slowly until transparent. He interprets the findings with the different body fluids as a little iodin is added.

Archivos Españoles de Pediatría, Madrid

September, 1919, **3**, No. 9

Pathologic Anatomy and Clinic of Meningitis. F. Criado.—p. 513.
*Tuberculosis in Children. A. Muñoyerro and Bravo Frías.—p. 532.

Tuberculosis in Children.—Muñoyerro and Bravo Frías found tuberculosis in 195 of 3,000 children from 1 to 3 years old at a Madrid asylum and they examined 105 tuberculous child cadavers. The tuberculin tests showed 6.3 per cent. tuberculous at this early age, and the tuberculous cadavers formed 9.3 per cent. of the total. The thorax was primarily affected in the overwhelming majority. They encountered one case of unmistakable congenital tuberculosis. In only one of all the cadavers was the primary lesion in the intestine. They describe the clinical picture, and remark on the rarity of hemoptysis in children. They observed it in only two cases

Gaceta Médica de Cartagena

October, 1919, **2**, No. 22

Latent Appendicitis Flares up during Influenza. N. M. Paz.—p. 5.
Marriage of Lepers. J. A. Caballero L.—p. 10.

Medicina Ibera, Madrid

Oct. 18, 1919, **9**, No. 102

Spastic Organic Paraplegia with Contracture. Manuel de los Reyes. —p. 37. Conc'n.
Pathogenesis of Adenoids. Prada.—p. 42.

Oct. 25, 1919; **9**, No. 103

Cystitis of Genital Origin. M. Barragán y Bonet.—p. 57.
Necessity for Inoculation of Animals in Diagnosis of Tuberculous Processes. Angel López.—p. 62.

Plus-Ultra, Madrid

July, 1919, **3**, No. 13

*Topography of Liver and Right Kidney Tumors. Serés.—p. 5.
*Abdominal Carcinomatosis. F. Salgado Benavides.—p. 10.
Recent Progress in Ophthalmology.—p. 14; in Obstetrics and Gynecology.—p. 23; in Bacteriology.—p. 32; in Otorhinolaryngology.—p. 37; in Heart Disease.—p. 43; in Instruments, etc.—p. 60.
*Kidney Anomalies and Surgery. Ara Sarrió.—p. 16.
*Stovain and the Blood Pressure and Heart. F. Alsina, T. Rodriguez and M. Bañuelos.—p. 19.
*Pneumococcus Peritonitis. Victoriano Juaristi.—p. 30.
The Diet After Gastro-Enterostomy. J. L. Yagüe y Espinosa.—p. 36.
Syphilitic Liver Colic. Pedro Escudero.—p. 40.
The Opsonin-Inducing Power of Serums. Juan Peset.—p. 47.
*Acute Mercurial Polyneuritis. W. López Alho.—p. 50.
Roentgen Study of the Circulation in the Brain. A. Herrera Carmona.—p. 57.

Topography of Liver and Right Kidney Tumors.—Serés comments on the difficulty in certain cases in distinguishing between a tumor in the liver and in the right kidney. The liver may sag so that it may present in the lumbar region, or be in contact with the abdominal wall, and the kidney may likewise be in either of these positions. He gives a number of illustrations showing the conditions aiding to distinguish a kidney tumor from an extrarenal tumor, and explain the displacement of the liver liable with either.

Abdominal Carcinomatosis.—In Salgado's case the man of 45 died in four months from the first symptoms. The viscera and especially the liver presented cancerous degeneration to an unprecedented extent. The article is illustrated.

Kidney Anomalies.—Three large views are given of some kidney anomalies which might puzzle the surgeon. One kidney shows three large arteries. A specimen from another case shows egg-shaped kidneys with multiple arteries.

Action of Stovain on Heart and Blood Pressure.—The experiments on dogs reported confirm the action of stovain on the sympathetic nervous system. Nothing was observed comparable to the fall of the blood pressure in man under stovain. The blood pressure was not modified in the dogs, but small doses by the vein induced a negative chronotropic action in the heart, along with a positive inotropic action. Larger doses reversed this, accelerating the rate of cardiac contraction while weakening the force of the beat.

Pneumococcus Peritonitis.—Juaristi discusses some of the problems presented by pneumococcus peritonitis, especially the best way to drain. In four of his own ten cases the disease had been mistaken for typhoid, and the surgeon had not been called in till the third week. In some of the other cases, puncture during the second week evacuated the pus; in others the pus opened its own way outward in a month. One girl had three of these spontaneous fistulas. This child died, as also two of the adults, although ample laparotomy had apparently improved conditions the tenth day and the third week. He warns of the treacherous lull that is common between the ninth and the twelfth days. Then the symptoms flare up again unless the abdominal cavity is thoroughly drained. He experimented on the cadaver, and found that a hole close to the sacrum, through the greater sacrosciatic ligament, effectually drains the abdomen without injuring any of the viscera. He suggests the advisability of draining in this way, introducing a trocar from without or from within, working down from the pelvis at the lower inner margin of the greater sciatic notch or in the ischiorectal fossa as preferred. With ample drainage thus ensured, the laparotomy incision might be sutured. His diagrams show

the various ways and the feasibility of this pararectal method of draining. Another feature of pneumococcus peritonitis is the pronounced tendency to formation of pseudomembranes. To combat this he advises injection of 30 or 40 c.c. of horse serum at once after the operation. In his cases he could see the rapid melting away of the pseudomembranes under its action.

Acute Mercurial Polyneuritis.—López reports in detail what he thinks is the third case of the kind on record. The acute polyneuritis followed ingestion of 2 gm. of calomel in three doses. The extreme constipation prevented the elimination by the bowel. The patient was a woman of 36, and the three doses were taken with three and eight days' intervals. Chronic polyneuritis from mercurial poisoning is comparatively common; he cites a long list of cases of this chronic kind.

Prensa Médica Argentina, Buenos Aires

Sept. 10, 1919, **6**, No. 10

General Plan for Prophylaxis of Tuberculosis. G. Aráoz Alfaro.—p. 93.
Toxicity of Indians' Curare. J. Guglielmetti and G. Pacella.—p. 102. Concluded in No. 11, p. 108.

Sept. 20, 1919, **6**, No. 11

*Tardy Inherited Syphilis. M. R. Castex and J. Palacio.—p. 105.
Generalized Subcutaneous Emphysema after Fracture of Ribs. N. Tagliavacche.—p. 111.

Tardy Inherited Syphilis.—Castex and Palacio here conclude their long study of tardy syphilitic disease of glands, spleen and blood, based on extensive personal experience and on the literature. They credit Resio with the first clinical and anatomic demonstration of the considerable share of tardy inherited syphilis in the pathogenesis of Banti's disease, and the possibility of a complete cure under mercurial treatment if begun in time. Enlargement of the spleen at 29, progressive pernicious anemia in the thirties, aleukemic lymphadenosis in children, paroxysmal hemoglobinuria, chronic hemolytic jaundice with enlarged spleen, and glandular disease in the neck in adults—instances of all these are reported in which the prompt retrogression under mercury and iodid confirmed their syphilitic nature. When the lesions are too long established, not much benefit from any treatment can be anticipated.

Siglo Médico, Madrid

Oct. 18, 1919, **66**, No. 3436

*Major Hysteria. E. Fernández Sanz.—p. 881.
*The Renal Factor in Glycosuria. Eduardo Bonilla.—p. 883.

Hysteria Major.—Fernández reports two extreme cases of hysteria in young women. One had been having for seven years congestion in various regions, including the eyelids and throat, fleeting edema, hemorrhages, especially from the stomach, attacks of retention of urine for several days, compelling the use of the catheter, and occasional periods of delirium, with long conversations with imaginary persons. In the other woman the hysteria caused convulsions, the clonic and tonic contractions keeping up for several hours several times a day, with a lethargic condition during the intervals. There was nothing in the patient or the family history to suggest any predisposing factors in this case, except zones of hyperalgesia in the scalp, lids and precordium. The symptoms had developed first after an attack of influenza during which venesection was done twice. The convulsions followed at once after the venesection, and have persisted very frequent and distressing to date.

The Renal Factor in Glycosuria.—Bonilla warns that while sugar in the urine indicates some disturbance in the metabolism of carbohydrates, this disturbance may be of various origins. Physicians are apt to overlook this, and label every case of glycosuria as diabetes.

Oct. 25, 1919, **66**, No. 3437

Muscular Rheumatism. Simón Hergueta.—p. 905.
*Tuberculous Spondylitis. Decref.—p. 909. Conc'n.
Tin in Treatment of Staphylococcus Infections. A. Froin.—p. 912.

Vertebral Tuberculosis.—Decref dismisses tuberculin as of no use whatever in external tuberculosis, according to the universal opinion. But heliotherapy has proved a powerful adjuvant for centuries. The excavations at Korbus, he says, near Tunis, have shown inscriptions dating from 42 B. C. recording the efficacy of sun baths and saline baths in the treatment of vertebral caries. Families are apt to carry to extremes the directions given them, and allow the children to take sun baths even up to four hours in an August noon, but the children in Spain seem to thrive under them and the focus improves in a few months to equal what is realized elsewhere only in a year or two.

He gages the length of the sun baths mainly by the temperature after the exposure. Simple and harmless heliotherapy, which costs absolutely nothing, has been applied by physicians over two thirds of Spain to an extent and with an efficacy beyond the highest dreams of many foreign physicians elsewhere. He pleads for heliotherapy as a routine measure in treatment of even the most neglected and desperate cases. Good results cannot be expected when only a small area is exposed through an opening in the plaster cast. The patients begin to improve at once when the opening in the cast is closed and a full sun bath taken. This is the case also with hip disease, even when the pelvis is in a cast.

The hemoglobin may play in human beings the same rôle as chlorophyll in plants. The fluorescent pigments, chlorophyll in plants and urobilin and bilirubin in animals, may destroy toxins and microbes to a certain extent under the action of sunlight. The action of the sunlight seems to take place mainly in the superficial circulation.

Decref extols the Lorenz and Redard frames for vertebral caries as offering the best conditions for immobilization while permitting heliotherapy. He decries the Albee and Hibbs operative measures as illogical, and contraindicated during the early phases. Time will show whether they should not be discarded completely as complicated, useless or harmful in all other stages of the disease. They should be reserved for cases with a progressive course in spite of systematic other treatment.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

Sept. 27, 1919, **2**, No. 13

*Typhus. P. H. Kramer.—p. 894.
*Position of the Yellow Spot in Relation to the Optic Nerve. G. Ten Doesschate.—p. 906.
Organization of Public Health Service. H. H. Van Eyk.—p. 913.
*Hysteria in Children. H. Bolten.—p. 915.
Abnormally Short Umbilical Cord. J. A. H. van den Berg.—p. 922.

Typhus.—Kramer applied the agglutination test with the proteus X in 119 cases of typhus at Rotterdam, and found it decisive at a dilution of 1:500 or higher, but it threw no light on the prognosis. The Widal agglutination test was positive late in typhus in 10 per cent. of the cases.

The Yellow Spot in Relation to the Optic Nerve.—Ten Doesschate reports two cases in which the relative location of the yellow spot and the optic nerve differed widely from the classic descriptions. He refers to some other recently published cases showing similar anomalies, and theorizes to explain them.

Hysteria in Children.—Bolten reports eight cases which illustrate the manifold forms that hysteria may assume in children. He calls attention to the hypotony in the sympathetic nervous system which he has found constantly in children and adults with hysteria. He thinks research on the vegetative nervous system in hysteria may throw new light on it. Erlenmeyer saw ameboid movements in the pupils of one patient during attacks of a hysterical nature. No stigmata of hysteria were evident in Bolten's eight cases, and all improved under psychotherapy, instructing and training the children to exert their will power not only to arrest an attack but to overcome the tendency to hysteria. By thus making the child realize that he himself has aided in throwing off the pathologic condition, much more is gained than can be obtained by hypnosis, rapidly acting suggestion, etc., which leave the causal hysteria unmodified. All the persons with hysteria that he has examined had various trophic disturbances, especially in the nails and teeth, and there were often vasomotor disturbances, spastic constipation and other signs of a substandard sympathetic nervous system. This was confirmed by the subsidence of these disturbances under thyroid treatment.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JULY-DECEMBER, 1919

The following journals have been abstracted in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Acta Medica Scandinavica. Irregular. 20 kronor. Stockholm.
Acta Scholae medicinalis universitatis imperialis in Kioto. Irregular. 1.50 yen. Kioto.
Amazonas medico. Q. Manaos.
American Journal of Anatomy. Bi-m. $7.50. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $8. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. William Wood & Co., 51 Fifth Ave., New York.
American Journal of Ophthalmology. M. $10. 7 W. Madison St., Chicago.
American Journal of Orthopedic Surgery. M. $4. 126 Massachusetts Ave., Boston.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore.
American Journal of Public Health. M. $3. 126 Massachusetts Ave., Boston.
American Journal of Roentgenology. M. $5. 69 E. 59th St., New York.
American Journal of Syphilis. Q. $5. C. V. Mosby Co., St. Louis.
American Review of Tuberculosis. M. $3. 2419 Greenmount Ave., Baltimore.
Anales de la Facultad de medicina, Montevideo. Bi-m. $2. Montevideo.
Anales de la Facultad de medicina, Universidad de Lima. Bi-m. 6 soles. Lima, Peru.
Anales del Instituto Modelo de clinica médica. Irregular. Gratis. Buenos Aires.
Annaes Paulistas de medicina e cirurgia. M. 15 milreis. São Paulo.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
Annales de médecine. M. 23 francs. Paris.
Annali d'igiene. M. 20 lire. Rome.
Annals of Medical History. Q. $6. Paul B. Hoeber, 67 E. 59th St., New York.
Annals of Otology, Rhinology and Laryngology. Q. $6. Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $6. J. B. Lippincott Co., 227 S. 6th St., Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Archives of Diagnosis. Q. $2. 141 W. 36th St., New York.
Archives of Internal Medicine. M. $5. American Medical Association, 535 N. Dearborn St., Chicago.
Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 22 francs. Paris.
Archives médicales belges. M. 18 francs. Paris.
Archives de médecine des enfants. M. 18 francs. Paris.
Archives de médecine et de pharmacie militaires. M. 40 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Neurology and Psychiatry. M. $5. American Medical Association, 535 N. Dearborn St., Chicago.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 2 W. 45th St., New York.
Archives of Radiology and Electrotherapy. M. $5. London.
Archivos brasileiros de medicina. M. 25 milreis. Rio de Janeiro.
Archivos españoles de enfermedades del aparato digestivo y de la nutricion. M. 14 pesetas. Madrid.
Archivos españoles de pediatria. M. 18 pesetas. Madrid.
Archivos españoles de tisiologia. Three numbers a year. 30 pesetas. Barcelona.
Archivos de Ginecopatia, Obstetricia y Pediatria. M. 21 ptas. Barcelona.
Archivos Latino-Americanos de pediatria. Bi-m. $3. Buenos Aires.
Arquivos do Instituto bacteriológico Camara Pestana. Price varies. Lisbon.
Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.
Brain. A Journal of Neurology. Irregular. $4. London.
Brazil-medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Irregular. 5 shillings. Clifton, Bristol.
British Journal of Children's Diseases. Q. $5. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $1.25. G. E. Stechert & Co., 151 W. 25th St., New York.
British Medical Journal. W. $10. London.
Bulletin de l'Académie de médecine. W. 23 francs. Paris.
Bulletin médical. Semi-w. 14 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $3. Baltimore.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. (except June, July, August and September) 25 cents. Medical and Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore.
Bulletin of the Naval Medical Association of Japan. Irregular. Tokio.
Bulletin of the Porto Rico Medical Association. Q. San Juan, Porto Rico.
Bulletins et mémoires de la Société médicale des Hôpitaux de Paris W. 32 francs. Paris.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Journal of Mental Hygiene. Q. $2. 121 Bishop St., Montreal.
Canadian Medical Association Journal. M. $5. 386 Victoria St., Toronto.
Canadian Medical Quarterly. Q. $3. Macmillan Company, Toronto.
China Medical Journal. Bi-m. $5 Shanghai.
Chirurgia clinica. M. 45 lire. Milan.
Chirurgia degli organi di movimento. Bi-m. 35 lire. Bologna.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. W. 22 francs. Basel.
Crónica médica. Semi-m. 15 francs. Lima, Peru.
Crónica médico-quirúrgica de la Habana. M. 4 pesos. Havana.
Delaware State Medical Journal. M. $1. Wilmington.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Endocrinology: Bulletin of the Association for the Study of Internal Secretions. Q. $5. 1100-1103 Title Insurance Bldg., Los Angeles.
Gaceta de los hospitales. Revista mensual de ciencias médicas. M. $5. Mexico.
Gaceta Médica. Semi-m. Cartagena.
Gaceta médica de Caracas. Semi-m. 16 bolivares. Caracas, Venezuela.
Gaceta médica de México. Irregular. $6. Mexico City.
Gaceta médica de Costa Rica. M. $6.00. Costa Rica.
Gann. Irregular. Tokio.
Gazzetta degli ospedali e delle cliniche. Semi-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago.
Indian Journal of Medical Research. Q. 10s. Calcutta.
Indian Medical Gazette. M. $5. Calcutta.
Japan Medical World (Nippon No Ikai). W. Tokio.
Journal of Abnormal Psychology. Bi-m. $4. 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. Boyle Bldg., Little Rock, Ark.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of Bacteriology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of Biological Chemistry. M. $3. 2419 Greenmount Ave., Baltimore.
Journal of Cancer Research. Q. $5. Williams & Wilkins Company, Baltimore.
Journal de chirurgie. M. 44 francs. Paris.
Journal of Cutaneous Diseases. M. $5. 7 W. Madison St., Chicago.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1.50. P. O. Box 136, Jacksonville, Fla.
Journal of General Physiology. Bi-m. $5. Rockefeller Institute for Medical Research, 66th St., and Avenue A, New York.
Journal of Immunology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of the Indiana State Medical Association. M. $2. 406 W. Berry St., Fort Wayne, Ind.
Journal of Industrial Hygiene and Abstract of the Literature. M. $5. Macmillan Company, 64-66 Fifth Avenue, New York.
Journal of Infectious Diseases. M. $5. 629 S. Wood St., Chicago.
Journal of Iowa State Medical Society. M. $2. Des Moines.
Journal of Kansas Medical Society. M. $2. 303 Commerce Bldg., Topeka, Kan.
Journal of Laboratory and Clinical Medicine. M. $3. C. V. Mosby Company, St. Louis.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Lamar Bldg., Augusta, Ga.
Journal of Medical Research. Bi-m. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 12 Cone St., Orange, N. J.
Journal de médecine de Bordeaux. M. 15 francs.
Journal of Michigan State Medical Society. M. $3.50. Powers' Theatre Bldg., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3517 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $8. 64 W. 56th St., New York.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Parasitology. Q. $2. Urbana, Ill.
Journal of Pathology and Bacteriology. Irregular. £1.1s. Cambridge, England.
Journal of Pharmacology and Experimental Therapeutics. M. $5. 2419 Greenmount Ave., Baltimore.
Journal de radiologie et d'électrologie. M. 28 francs. Paris.
Journal of South Carolina Medical Association. M. $2. Greenville, S. C.
Journal of State Medicine. M., 2 shillings. London.
Journal of Tennessee State Medical Association. M. $2. 601 Cedar St., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal d'urologie médicale et chirurgicale. M. 42 francs. Paris.
Journal of Urology. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Kentucky Medical Journal. M. $2. State and Twelfth Sts., Bowling Green, Ky.
Kitasato Archives of Experimental Medicine. Twice a year. 60 cents. Tokio.
Lancet. W. $10. London.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. M. 15 francs.
Médecine. M. 18 francs. Paris.
Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië. Irregular. Price varies. Batavia, Java.
Medical Journal of Australia. W. 6 d. Sydney.
Medical Journal of the Siamese Red Cross. 5 ticals. Bangkok.
Medical Journal of South Africa. M. £1.1. Johannesburg.
Medical Quarterly. Department of Soldierrs' Civil Re-establishment, Board of Pension Commissioners for Canada, Ottawa.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medicina Ibera. W. 25 pesetas. Madrid.
Mental Hygiene. Q. $2. National Committee for Mental Hygiene, 50 Union Square, New York City.
Military Surgeon. M. $3.50. Army Medical Museum, Washington, D. C.
Minnesota Medicine. M. $2. Lowry Bldg., St. Paul.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität Kyushu. Irregular. Price varies. Fukuoka.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irregular. Price varies. Tokio.
Modern Hospital. M. $3. Metropolitan Bldg., St. Louis.
Modern Medicine. M. $3. 58 E. Washington St., Chicago.
National Medical Journal of China. $2. Shanghai.
Nebraska State Medical Journal. M. $2.00. 468 Brandeis Bldg., Omaha.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $2. 17 W. 43d St., New York.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Nourrisson. Bi-m. 14 francs. Paris.
Observaciones y Notas. M. Bs. 4. San Cristóbal, Venezuela.
Ohio State Medical Journal. M. $2. Physician's Bldg., Columbus.
Paris médical. W. 16 francs.
Pediatria. M. 20 lire. Naples.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Monthly. $5. Manila, P. I.
Plus-Ultra. Revista internacional de ciencias médicas. M. 60 pesetas. Madrid.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Prensa médica argentina. Semi-m. 25 francs. Buenos Aires.
Presse médicale. Semi-w. 15 francs. Paris.
Progrès médical. W. 12 francs. Paris.
Progresos de la clinica. M. 25 pesetas. Madrid.
Psychobiology. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Public Health Journal. M. $2. York Publishing Co., 169 Bay St., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Reforma medica. M. 6 soles. Lima.
Repertorio de medicina y cirugia. M. $3. Bogotá, Colombia.
Revista clinica. Q. $1. Medellin.
Revista cubana de obstetricia y ginecologia. M. $3. Havana.
Revista de la Asociación médica argentina. M. Buenos Aires.
Revista de medicina y cirugia de la Habana. Semi-m. $4.50. Havana.
Revista de la Universidad de Buenos Aires. M. $5. Buenos Aires.
Revista de medicina y cirugia prácticas. W. 30 pesetas. Madrid.
Revista de psiquiatria y disciplinas conexas. Q. $3.00. Lima.
Revista del Instituto bacteriologico. Q. Buenos Aires.
Revista dos Cursos. Irregular. Porto Alegre.
Revista Española de medicina y cirugia. M. 24 pesetas. Barcelona.
Revista médica. M. $5. Puebla.
Revista médica cubana. M. Havana.
Revista médica de Bogotá. M. Bogota.
Revista médica de Chile. M. Santiago.
Revista médica de Yucatán. M. 6 pesos. Mérida.
Revista médica del Rosario. Bi-m. 10 pesos. Rosario, Argentina.
Revista médica del Uruguay. M. 30 francs. Montevideo.
Revista medico-cirurgica do Brazil. M. 10 milreis. Rio de Janeiro.
Revista sud-americana de endocrinologia, inmunologia y quimioterapia. M. $5. Buenos Aires.
Revue de chirurgie. M. 33 francs. Paris.
Revue de médecine. M. 23 francs. Paris.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Riforma medica. W. 35.50 lire. Naples.
Revue francaise de gynécologie et d'obstétrique. Semi-m. 18 francs. Paris.
Revue neurologique. M. 45 francs. Paris.
Rivista critica di clinica medica. W. 16 lire. Florence.
Rivista di clinica pediatrica. M. 18 lire. Florence.
*Schweizer Archiv für Neurologie und Psychiatrie. Irregular. Price varies. Zurich.
Sei-I-Kwai Medical Journal. M. $2. Tokio.
Semana médica. W. $5. Buenos Aires.
Siglo médico. W. 20 pesetas. Madrid.
Social Hygiene. Q. $2. 2419 Greenmount Ave., Baltimore.
Southern Medical Journal. M. $3. 807 Empire Bldg., Birmingham, Ala.
Southwest Journal of Medicine and Surgery. M. $1. El Reno, Okla.
Southwestern Medicine. M. $2. El Paso, Texas.
Surgery, Gynecology and Obstetrics with International Abstract of Surgery. M. $10. Surgical Publishing Co., 30 N. Michigan Ave., Chicago.
Svenska Läkaresällskapets Handlingar. Q. 7.50 kroner. Stockholm.
Texas State Journal of Medicine. M. $2.50. Western National Bank Bldg., Fort Worth, Tex.
Tubercle. M. 25 shillings. London.
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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "MI," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

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SOCIETIES

A.—Association
Acad.—Academy
Am.—American
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical or Medicine
Nat.—National
Pharm.—Pharmaceutical
Phys.—Physicians
Ry.—Railway
S.—Society
Surg.—Surgical, Surgeon or Surgery

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